Utah Division of Services for People with Disabilities (DSPD)
Person-Centered Planning (PCP)
Foundational Handbook for Support Coordinators

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Letter from the Director

Dear Support Coordinators,

The mission of the Division of Services for People with Disabilities (DSPD) is to promote opportunities and provide support for the diversity of people who have disabilities to lead self-determined lives. Your role as a Support Coordinator is to foster self-determination, in part through facilitation of the Person-Centered Planning (PCP) process.

As systems have shifted from that of limiting, institutional models to expansive, community-based models, person-centered planning has become key to ensuring community integration and inclusion afforded to people with disabilities in Home and Community Based Services (HCBS) under the Settings Rule.

The following handbook was created both as a reference for Support Coordinators already familiar with person-centered practices, and as a learning guide for those who are new to person-centered thinking and planning. This manual outlines the foundational principles and requirements of the PCP process, and will include technical guidance on using the Utah System for Tracking Eligibility, Planning and Services (USTEPS) to create an electronic Person-Centered Support Plan (PCSP) in the future.

The content of this manual was created with the assistance of people with disabilities, self-advocates, families, Support Coordinators, service providers, community partners, and subject matter experts through the National Center on Advancing Person-Centered Practices and Systems (NCAPPS). It reflects DSPD's continued commitment to ensuring that people with disabilities are able to lead the lives they desire through the implementation of person-centered practices throughout our system.

Thank you for your continued dedication to serving and supporting the people in our services.

Angella Pinna

Director, Division of Services for People with Disabilities

Person-Centered Thinking (PCT)

"For people being supported by services, it is not person-centered planning that matters as much as the pervasive presence of person-centered thinking."
– Helen Sanderson

In order for you, the Support Coordinator, to effectively facilitate the Person-Centered Planning (PCP) process, you must first be a person-centered thinker. Person-Centered Thinking (PCT) is the foundation for PCP. PCT is the belief or mindset that people with disabilities are the experts of their own lives and what a good life looks like for them. A "good life" looks different for everybody. It can include happiness; health and safety; employment; hopes and dreams; meaningful activities; close relationships with family, friends, and significant others; and being included in your community in a meaningful way. PCT provides the foundation for the practices that establish the means for a person to live a life that they, and those who care about them, have good reasons to value.[1] PCT takes the person's cultural and social identities into consideration as well. Although many of us already believe we are person-centered, it is important for us to remain continuously open to re-examining and re-assessing where we truly are. Continued refreshing of PCT is beneficial to all of us, new and seasoned professionals, to avoid limiting a person's choices or controlling their lives.

When you are person-centered, it means you:

- Believe the person with the disability is whole and has dreams, talents and skills to offer to the world
- Look for the good in the person and try to bring it out to the best of your abilities
- Truly want to know and understand the whole person including their cultural identities and life experiences

[1] Centers for Medicare and Medicaid (2016). System-Wide Person-Centered Planning [PowerPoint Slides]. Retrieved from https://www.medicaid.gov/sites/default/files/2019-12/system-wide-person-centered-planning.pdf

- Are willing to push for the person's goals that may seem difficult or impossible
- Are flexible, creative and open to trying what might be possible[2]

PCT supports people having positive control over their lives by ensuring they are at the center of decisions that are made about all aspects of their existence. Individuals are able to make decisions for themselves throughout all life domains: daily life and employment; community living; healthy living; safety and security; social and spirituality; and advocacy and engagement.

Video Resources

- Stacy Danov, a Support Coordinator, shares a story about the positive effects of utilizing person-centered thinking with a person she supports: https://www.youtube.com/watch?v=cVeyg6woFwg
    - Questions to consider while watching the video:
        - How did Stacy start to learn about Leigh?
        - What process did Stacy take to help Leigh achieve her dreams? What steps were taken?
        - What are the benefits of taking a person-centered thinking approach?
- People in services discuss the positive impact person-centered thinking has had on their lives: https://www.youtube.com/watch?v=NLPVxO13KeU
    - Questions to consider while watching the video:
    - How did the individuals' lives change after using person-centered thinking?
    - What advice do the individuals have for how others around them can become more person-centered?
- Michael Smull, a pioneer of person-centered thinking, reflects on the philosophy: https://www.youtube.com/watch?v=2rmLtU6FYBE
    - Questions to consider while watching the video:
        - Where did person-centered thinking come from?
        - What is the "working definition" of a good life?
        - What is the "danger" of person-centered thinking?
        - What does person-centered thinking require?

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[2] Brown, Adonis (2016). Self-Advocacy, Self-Determination, and Person-Centered Planning [PowerPoint Slides]. Retrieved from http://convention.thearc.org/wp-content/uploads/2016/11/Self-Advocacy_Self-Determination_Person-Centered-Planning-ATBrown.pdf

Person-Centered Planning (PCP)

"Person-centered planning grew out of a passionate concern to support people with developmental disabilities in discovering and contributing their gifts." - Connie Lyle O'Brien and John O'Brien

The Person-Centered Planning (PCP) process is a personalized approach to planning services and supports to help the person get both what is important to them and important for them. PCP is a way to assist people in constructing and describing what they want and need to bring purpose and meaning to their life.[3] PCP is based on the person and not on their diagnosis. The person's services and supports should help them reach their vision of a good life, which includes their expressed goals, needs, and desires – both what is important to the person and important for them to achieve the life they want to live. PCP involves the person and others who the person wants to participate in the planning process, coming together to ensure that the person drives the creation of their Person-Centered Support Plan (PCSP) to the fullest extent they desire and ultimately achieve their goals. Choice, direction, and control are expressed by the person at all stages of the PCP process.

You can think of the PCP process as a restaurant menu:

"First comes the appetizer, a process of finding out who a person is and what his or her likes, character, abilities, and preferences are. The appetizer ingredients appear throughout the meal and set the stage for the rest of the meeting.

The second course is the entrée, which adds to the components of the appetizer a circle of support, opportunities, contact people, natural and paid supports, financial possibilities, and community settings. This part of the meal cannot be rushed. It takes time to make a good meal and a good personal plan for the future.

[3] Centers for Medicare and Medicaid (2016). System-Wide Person-Centered Planning [PowerPoint Slides]. Retrieved from https://www.medicaid.gov/sites/default/files/2019-12/system-wide-person-centered-planning.pdf

For dessert, the plan is set in motion with responsibilities and due dates, charts to stay on track, and an open chart for new ideas.

We can design the menu we want based on our individual needs. The same appetizers may not lead to the same entrée or dessert choices, and choice is what person-centered planning is all about."

- *Clara Berg and Arnie Mejia*[4]

PCP focuses on the person's strengths, skills, and accomplishments. In order for the PCP process to be successful, you must believe that the person is already whole and does not need to be fixed or changed; and meet the person where they are. You should presume the person is competent from the beginning, and believe in their ability to take an active role in the PCP process regardless of any preconceived notions you, or others, may have about them or their capabilities.

The Four P's of Person-Centered Planning

Quality Person-Centered Planning (PCP) consists of four elements:

- *Philosophy:* Believing that people have the fundamental right to maximum self-determination and community inclusion.
- *Process:* Interacting with people before, during, and after PCP meetings in a manner that communicates respect and a hopeful vision for the future.
- *Plan:* Translating person-centered philosophy and process into a high-quality written service planning document.
- *Purpose:* Ensuring that the PCP process helps people in getting what they want out of life.[5]

[4] Reiman, J., Malloy, P., & Clumps, R. (2008). Person-Centered Planning in the US. *Deaf-Blind Perspectives*, *Fifteen* (Two). Retrieved from https://documents.nationaldb.org/dbp/text/apr2008.txt

[5] Spokane County (n.d.). Introduction to the Documentation of Person-Centered Service Plans. Retrieved from https://www.spokanecounty.org/DocumentCenter/View/3024/Introduction-to-the-Documentation-of-Person-Centered-Service-Plans-PDF

What Person-Centered Planning Should Accomplish

Person-Centered Planning should lead to people:

- *Having control over the lives they have chosen for themselves*
    - Is the person able to develop and express autonomy in both everyday and life-defining manners?
    - Is the person able to make both significant and small choices in their life?
    - Does the person have multiple experiences to choose from and are they able to choose which activities they would like to participate in and with whom?
- *Being recognized and valued for their contributions (past, current, and potential) to their communities*
    - Is the person able to develop valued roles in their various communities?
    - What communities does the person want to be a valued member of?
    - Is the person able to access places in the community that are not specifically designed for individuals with disabilities (businesses, neighborhoods, community events, places of worship, etc.?)
- *Living the lives they want*
    - Is the person supported and enabled to perform functional, age-appropriate, and meaningful activities within the social-cultural contexts of the communities in which they live?

Defining Community

Community means different things to different people. For instance, it could mean a place, like your job or neighborhood. It could also be somewhere online, like through social media or gaming. The community could also be people, such as those who live by you, work with you, or those who are interested in the same things you are, like books or movies. Some questions you might want to ask the people you support include:

- What does community mean to you?
- What community do you want to be a part of?
- What do you enjoy doing with others?

We focus PCP on five valued experiences for the person:

- *Sharing ordinary places* and activities with other neighbors, classmates, co-workers, and members of shared cultural or faith communities. Living, working, learning, and participating confidently in ordinary community settings.
- *Belonging* in a diverse variety of relationships and memberships.
- *Being* respected as whole people whose history, capacities and futures are worthy of attention and whose gifts engage them in valued social roles.
- *Contributing* by discovering, developing, and giving their gifts and investing their capacities and energy in pursuits that make a positive difference to other people.
- *Choosing* what they want in everyday situations in ways that reflect their highest purpose.[6]

Requirements for the Person-Centered Planning Process

While the PCP process may look different from person to person, there are some requirements that must be met for everyone. Per CMS-2249-F/CMS-2296-F, the PCP process must:

- ✓ Be led by the person receiving services and supports where possible. The person's representative should have a participatory role, as needed and as defined by the person, unless State law confers decision-making authority to the legal representative. All references to people include the role of the person's representative.
- ✓ Include people chosen by the person.
- ✓ Provide necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
- ✓ Be timely and occur at times and locations of convenience to the person.

[6] O'Brien, J. (1989). What's worth working for. Leadership for Better Quality Human Services: Center on Human Policy, Syracuse University.

- ✓ Reflect cultural considerations of the person and is conducted by providing information in plain language and in a manner that is accessible to people with disabilities and people who are limited English proficient.
- ✓ Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
- ✓ Offer informed choices to the person regarding the services and supports they receive and from whom.
- ✓ Include a method for the person to request updates to the plan as needed.
- ✓ Record the alternative home and community-based settings that were considered by the person.

PCP does not mean that the person gets everything they want. Sometimes we desire things that are not feasible, or could potentially harm the health and safety of ourselves or others. Choices and preferences may not always be granted; they should, however, always be acknowledged and respected. If the person expresses goals or wishes that may seem impossible, try to determine the underlying reasons for their interests and more realistic and achievable ways of developing these interests. If we are unable to support the person's whole dream to come true, what is part of the dream that we can help make happen?

Video Resources

- Beth Mount describes the difference between Person-Centered and System-Centered planning: https://www.youtube.com/watch?v=2REk6fYDZ0Y
    - Questions to consider while watching the video:
        - What are the characteristics of a person-centered model? How does it differ from that of a system-centered model?
        - How do we shift our thinking from systems to people?
        - What does a good person-centered planning process look like?

- A success story about how using PCP changed a person's life: https://www.youtube.com/watch?v=PhiYISglx40
    - Questions to consider while watching the video:
        - What barriers did Larry face to achieving his dreams? How were those barriers overcome?
        - What was the process to get Larry into his own home and out into the community?
        - How has Larry's life changed since starting the person-centered planning process?

Trauma Informed Person-Centered Planning

PCP is a trauma-informed process, meaning that it recognizes and responds to people's past trauma while resisting re-traumatization. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "Individual trauma results from an event, series of events, or set of circumstances experienced by a person as physically or emotionally harmful or life-threatening with lasting adverse effects on the person's functioning and mental, physical, social, emotional, or spiritual well-being."[7] Any event can be traumatic if it overwhelms our ability to cope. Often the word trauma is associated with experiences such as physical abuse, sexual abuse, neglect, and restraints. These are examples of "big T" trauma. However, smaller life experiences can add up to one big thing. This is called "little t" trauma. Common examples of "little t" trauma for people with disabilities include bullying, everyday discrimination, daily physical care without consent, disempowerment in decision-making, high staff turnover, chronic health conditions, and unaccommodated sensory sensitivities. Appropriate services, supports, and intervention can help a person process traumatic experiences.

[7] Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). Trauma and Violence. Retrieved from https://www.samhsa.gov/trauma-violence

Being trauma-informed means bringing sensitivity and compassion to your work as a Support Coordinator, because you have an awareness of what the people you support have been through, and that people may have experienced trauma that is unknown to you. It is important to assume that trauma influences the person's choices and behavior, do not, however, actively seek to uncover trauma unless you are able to respond to it effectively.

PCP is consistent with trauma-informed care principles and practices. PCP and trauma-informed care both attempt to create a process where:

- The person's physical and emotional wellbeing is cared for and respected.
- Transparency is encouraged with the goal of building and maintaining trust.
- Collaboration is made possible through the involvement of the person's circle of support, peers, and community.
- The person is treated with dignity and respect; and acknowledged for their strengths.
- The person is given choices so that they can make informed decisions.
- The person's cultural, social, and environmental needs are addressed; along with their historical trauma, stereotypes, and biases.[8]

Reminder: Developing a great plan that is not implemented is another trauma.[9]

As you support the person through the PCP process, consider how you can make the person feel comfortable, safe, and included. Approach the person with compassion and assume the person has the best of intentions. If at any point in the PCP process, you begin to attach a negative label to a person, it is important to self-reflect on why you may be doing so and how to change it.

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[8] Trauma Informed Oregon. (2016). Person-Centered Planning: A Trauma Informed Best Practice. PDF.

[9] Richmond, T. (2019). Trauma-Informed Person-Centered Thinking and Support [PowerPoint Slides]. Retrieved from https://ncapps.acl.gov/docs/NCAPPS%20November%20Webinar%20Presentation%20-%20Combined%20and%20Accessible.pdf

Trauma-Informed Person-Centered Planning: A Guide for People with Disabilities and the Professionals and Family Members Who Provide Supports: https://static1.squarespace.com/static/583e226f440243877a197542/t/5b9a93820e2e72572887bfbb/1536856963196/Trauma+Informed+Person+Centered+Planning+Guide+-+Final+9.13.18.pdf

A Trauma Informed Toolkit for Providers in the Field of Intellectual and Developmental Disabilities: https://www.acesconnection.com/fileSendAction/fcType/0/fcOid/468137553002812476/filePointer/468137553002812517/fodoid/468137553002812512/IDD%20TOOLKIT%20%20CFDS%20HEARTS%20NETWORK%205-28%20FinalR2.pdf

Explicit and Implicit Bias

*Unless otherwise stated, the content in this section is attributed to the Georgetown University National Center for Cultural Competence (2017).[10]

Bias is a preference for one thing, person, or group over another. Bias is a natural human reaction and we all have biases; whether conscious/explicit or unconscious/implicit. Bias becomes a concern, however, when it becomes a prejudice against certain people or groups in ways that are unfair and lead to discrimination.

Biases are conscious or explicit when we are aware of the biases and are able to articulate what they are. Some examples of how explicit bias may show up in the work environment include:

- "I don't like working with…" (age, gender, sexual orientation, specific disabilities)
- "It takes too long and it is too hard when I have to work with people who need an interpreter."

Biases are unconscious or implicit when we are unaware of the biases and often deny that we have them (whether to ourselves or others). Some examples of how implicit bias may show up in the work environment include:

- "That type of discrimination is in the past."
- "I treat everyone fairly - I never make differences based on someone's race or culture."
- "I don't see color."
- "We focus only on the culture of disability."

[10] Goode, T., Georgetown University National Center for Cultural Competence (2017). Confronting and Addressing Conscious and Unconscious Biases and the "ISMs" [PowerPoint Slides]. Retrieved from https://nccc.georgetown.edu/leadership/documents/2017Forum1%20LearningReflectionPPT.pdf

According to Cook Ross Inc.,[11] some questions you may ask yourself to help recognize and acknowledge implicit biases include:

- What are my biases and blind spots?
- Do I have an automatic feeling or judgement about this person?
- Am I being reminded of someone?
- What is this person triggering in my background?
- Do I notice any patterns in my decision making or actions that might be impacted by my biases?
- How might I consciously intervene to mitigate the impact of this bias?

Thought Exercise

Project Implicit: Take an Implicit Association Test (IAT) to examine your attitudes and beliefs about certain groups of people. The IAT measures attitudes and beliefs that people may be unwilling or unable to report. The IAT may be especially interesting if it shows that you have an implicit attitude that you didn't know about*:
https://implicit.harvard.edu/implicit/takeatest.html

*Disclosure: It is important to note that the IAT disability test is limited in that it depicts disability from a physical and sensory perspective. In terms of accessibility, the IAT does not work for individuals who are blind or have physical disabilities that would affect their ability to use their hands quickly to respond to the timed projected images. Additionally, there are conflicting studies as to the efficacy of the IAT.

[11] Cook Ross Inc., Unconscious Bias (n.d.). Retrieved from: https://dent.umich.edu/sites/default/files/2019-04/UB%20Takeaway%20Sheet_42715%20%281%29.pdf

Values of Person-Centered Thinking (PCT) and Planning (PCP)

The values of Person-Centered Thinking (PCT) and Planning (PCP) are the guiding principles that ensure the person remains at the center of the planning process, and decisions about their life. These values include self-determination, community inclusion, community integration, cultural competency, informed decision making, informed choice, dignity of risk, individual rights, balancing important to and for, and communicating with people who communicate without words.

Self-Determination

Self-determination is the freedom of people with disabilities to make choices about their own life without the undesired influence of others; and to have the same rights and responsibilities as those without disabilities. Self-determination involves choosing and setting goals, being involved in making one's own life decisions, and advocating for oneself.

The core values of self-determination include:

- Independence to make choices about services and supports
- Authority to decide how one's income and support funding is used
- Support from a network of resources including natural supports and the community
- Responsibility to be accountable for decisions and to give to one's community

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Resources

- Self-advocate Betty Williams describes what self-determination means to her in this video: https://www.youtube.com/watch?v=zdAnid3kC2w
- Tawara Goode describes how the perception and practice of self-determination can vary across multiple cultural groups in this article: https://publications.ici.umn.edu/impact/32-1/self-determination-cultural-differences-in-perception-and-practice

Community Inclusion

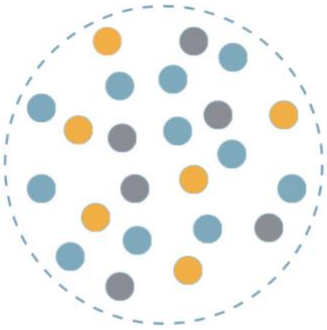
Community inclusion is the right of people with disabilities to live in and have full access to their community to the same extent as those people without disabilities; while being valued and treated with dignity and respect.[12]

People should be considered first (self-determination), then within the context of family (whatever family means to them). People exist and have reciprocal roles within a family system, which adjust as the individual members change and age.

Finally, people should be considered within the context of their community. Community inclusion means actively working to bring people who have historically been excluded to "come in" to the community.

Community inclusion is successful when people have:

- Relationships with others who are not paid to spend time with them
- Opportunities to experience a variety of social roles that include friendships, contributing to the community and gaining new skills
- Resources and opportunities to do and accomplish things that are important to them



Inclusion

[12] Copley, C. (2020, March 4). Integration vs. Inclusion. Retrieved from http://www.dcbdd.org/uncategorized/integration-vs-inclusion/

Video Resource

Disability Rights advocates from Green Mountain Self-Advocates describe the importance of inclusion: https://www.youtube.com/watch?v=4y8X_erb8EU

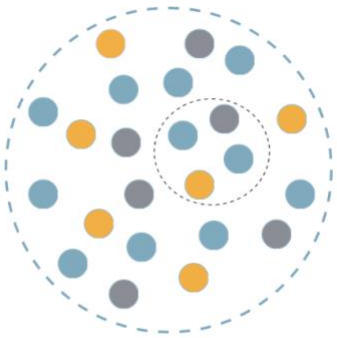
- Questions to consider while watching the video:
  - What is inclusion?
  - What are some of the benefits of inclusion?
  - How has inclusion affected the lives of the self-advocates in the video?

Community Integration

Community integration is the right of people with disabilities to live in the community and be valued for their uniqueness and abilities to the same extent as others without disabilities.[13] Community integration means actively working to not only bring people into their community, but also ensuring that they are able to contribute to the development of their community and feel like they are an integral part of it. People are not forced to be a part of any one community; they should be given the opportunity to participate in a variety of communities they are interested in.

Community integration is successful when people:

- Actively participate in their community
- Feel connected and engaged
- Are within an environment that facilitates their well-being



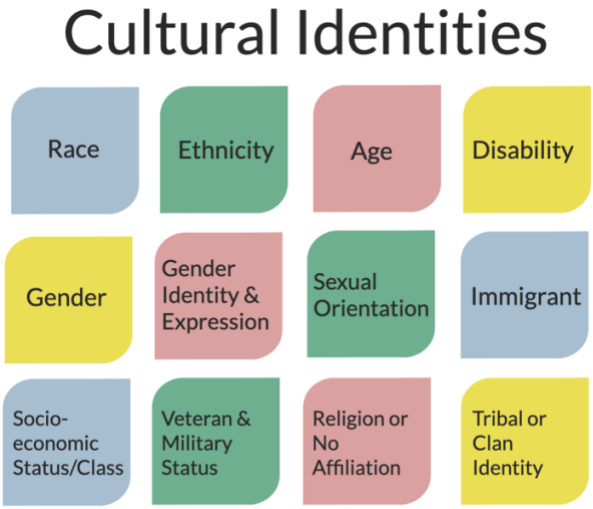
Integration

[13] Salzer, M.S., & Baron, R.C. (2006). Community integration and measuring participation. Philadelphia, PA: University of Pennsylvania Collaborative on Community Integration.

Culture, Cultural Identity, Intersectionality, and Cultural and Linguistic Competency

According to the Georgetown University National Center for Cultural Competence, culture is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. Culture applies to racial, ethnic, religious, political, professional, and other social groups. It can include, but is not limited to, communication, rituals, languages, relationships, thought, beliefs, values, practices, customs, roles, expected behaviors, and manners of interacting.

All people have multiple cultural identities. Cultural identity can impact personal values, experiences, and perspectives. A person's cultural identity can change over time throughout different phases of their lives as they reconcile their multiple roles.[14] It is important to consider all of the cultural identities the people you support may identify with and how those identities may influence them. When it comes to disability identity, it is crucial to remember that, "the population of people who experience disability is extraordinarily diverse and, therefore, the idea of a common disability identity isolates disability artificially from intersecting identities related to race, gender, sexuality, class, age, and other axes of social significance."[15]



[14] Giguère B., Lalonde R., Lou E. (2010). Living at the crossroads of cultural worlds: the experience of normative conflicts by second generation immigrant youth. Soc. Pers. Psychol. Compass 3, 1–16

[15] Goode, T., Georgetown University National Center for Cultural Competence (2018). Exploring Intersectionality and Multiple Cultural Identities within Developmental and other Disabilities [PowerPoint Slides]. Retrieved from https://nccc.georgetown.edu/leadership/documents/2018Jan25Forum1PPT.pdf

A person may experience discrimination, oppression, and marginalization due to their membership in overlapping or intersecting social groups. This is known as intersectionality. Sometimes those who use the term intersectionality confuse it with "multiple cultural identities" or the "intersections of identity" and they leave out the important issues of discrimination, marginalization, and oppression. People with disabilities have historically been treated differently because of their membership in multiple social groups that are marginalized.

Video Resource

- This video provides a brief overview of intersectionality: https://www.youtube.com/watch?v=O1islM0ytkE

Cultural competence means that services, supports, or other assistance is conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of people who are receiving services; and in a manner that has the greatest likelihood of ensuring their maximum participation.[16]

According to Goode (2019), the five elements of cultural competence are:

1. Acknowledge cultural differences
    a. Be attuned to both similarities and differences between and among people from all cultural groups.
2. Understand your own culture
    a. Examine whether and how your cultural belief systems may positively or negatively influence communication and relationships with the people to whom you provide services and supports and their families.
3. Engage in self-assessment
    a. Think "culture" when you think others are not behaving in ways you expect. Consider what values, norms, and beliefs you bring to the situation.

[16] 42 U.S.C. 15002

4. Acquire cultural knowledge and skills
    a. Make a personal and professional commitment to learn about people from cultural groups that are different than your own and how to translate this knowledge into skills.
5. View behavior within a cultural context
    a. Accept that people from racial, ethnic, and other cultural groups have historical and present-day experiences of bias, stereotyping, discrimination, and disparate treatment in health, mental health, and social services that affect their behavior.[17]

Linguistic competence means that information is conveyed in a manner that is easily understood by diverse groups, people of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.[18] Services and supports should be delivered in the preferred language and/or mode of delivery of the people supported; and written materials should be translated, adapted, and/or provided in alternative formats based on the needs and preferences of the people supported.

Resource

The Promoting Cultural Diversity and Cultural Competency: Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Needs and their Families can be used to heighten the awareness and sensitivity of professionals regarding the importance of cultural diversity and cultural competence in human service settings. Fill out the checklist for yourself and see what insights you may discover!

- https://nccc.georgetown.edu/documents/ChecklistCSHN.pdf

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[17] Goode, T., Georgetown University National Center for Cultural Competence (2019). Pieces of the Same Puzzle: The Role of Culture in Person-Centered Thinking, Planning, and Practice [PowerPoint Slides]. Retrieved from https://ncapps.acl.gov/docs/NCAPPS_PiecesOfThePuzzle_webinar_070919_FINAL.pdf

[18] Goode & Jones (modified 2009). National Center for Cultural Competence, Georgetown University Center for Child & Human Development. Retrieved from https://nccc.georgetown.edu/foundations/framework.php

Video Resource

Maychee Mua, an employee in the Minnesota Department of Human Services Disability Services Division, talks about her son's autism diagnosis, her family's refugee background and how more can be done to reduce stigma around disability: https://www.youtube.com/watch?v=BzkOQoA2FZ0

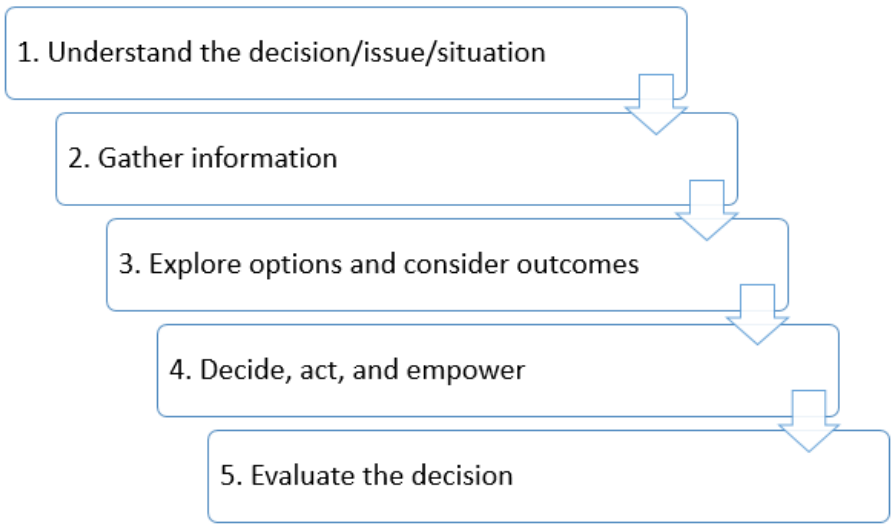
- Questions to consider while watching the video:
    - Why does Maychee believe some cultures don't talk about disability?
    - How did Maychee embrace disability?
    - Why did Maychee struggle to advocate for her son as a parent?
    - What does Maychee want to pass on to her children as they get older?

Informed Decision Making

Informed decision making is a process where a person obtains information and knowledge about a situation or problem in order to make an informed decision. With assistance from others who support or assist them, the person understands the choices available to them and the possible outcomes of their decision; along with accepting the associated responsibility and any potential risks of their final choice. Informed decision making ensures that when the person makes a final choice, it reflects their personal values, and not those of the people who are supporting or assisting them.

DSPD recommends using the National Alliance for Direct Support Professionals (NADSP) informed decision-making process which consists of five steps:

1. Understand the decision/issue/situation
2. Gather information
3. Explore options and consider outcomes
4. Decide, act, and empower
5. Evaluate the decision



Some important questions to consider as you help a person through the informed decision-making process include:

- What kind of decision is being made?
- Has the person made a decision like this before?
- What are the person's belief systems that may impact their decision?
- Has the person been assisted to understand the risks and benefits? How big is the impact of this decision on the person's life?
- How long would the person live with the decision? How hard would it be to undo?
- Who is evaluating the decision? By what criteria are they evaluating the decision?
- Are there others that the person would like to consult with about the decision?
- What is the least restrictive level of support that might work?[19]

Planning Tool Tip

Individuals may need support in three key areas related to their decisions/decision making:

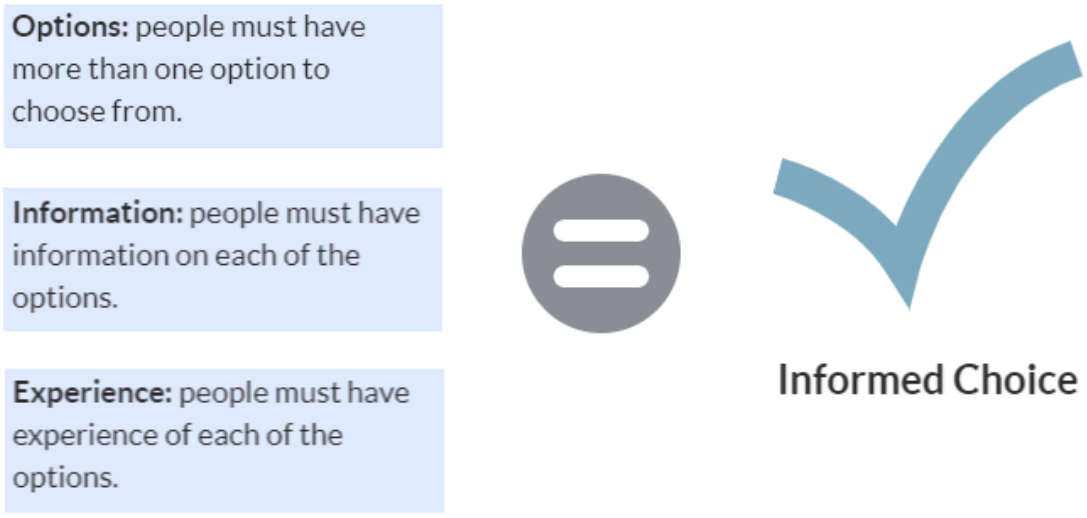
- Supports a person needs to understand their choices (information/advice)
- Supports a person needs to communicate their preferences (communication)
- Supports a person needs to follow through on their decision (reminders, logistics, etc.)

You may want to use the Charting the Life Course Tool for Exploring Decision Making Supports through the Informed Decision-Making process. The tool identifies areas in which a person will, or will not, need personalized supports to make important decisions. The Integrated Supports Star could be used to explore all of the options available to the person in order to make an informed choice. The Trajectory for Planning can also help people make decisions based on whether their choice will lead them toward their vision of a good life or away from it (towards what is not wanted). All Charting the LifeCourse tools can be downloaded for free at: https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/

[19] Raffaele, J. (2019). Informed Decision Making [PowerPoint Slides]. Retrieved from https://i2icenter.org/wp-content/uploads/2019/06/Informed-Decision-Making-Presentation.pdf

Informed Choice

A choice is informed when a person has options, information about the options, and experience with the options. Helping people make an informed choice involves providing or assisting them in acquiring information that enables them to exercise informed choice in the development of their Person-Centered Support Plan (PCSP) with respect to the selection of outcomes, supports and services, service providers, the most integrated settings in which the supports and services will be provided and methods for obtaining services. Those who assist and support the person must work together in order to ensure the person is gaining experience and knowledge about different options so that they are able to make an informed choice about what they want for their life.



Statements That Can Help and Hinder Informed Choice

According to Hoff & Holz (2020), the following statements can help facilitate a discussion regarding informed choice:

- "What type of things are you interested in?
- "Tell me more about why you're interested in that."
- "Why is that important to you?"
- "How would you go about learning more about that?"

The following statements can hinder a discussion regarding informed choice and should be avoided:

- "I really think you should do X."
- "You don't really want to do that, do you?"
- "I don't think you would be good at that."
- "What do you want to do that for?"[20]

Resource

- Employment and Employment Supports: A Guide to Ensuring Informed Choice for Individuals with Disabilities: https://www.communityinclusion.org/pdf/TO31_F.pdf

[20] Hoff, D., & Holz, N. (2020). Employment and Employment Supports: A Guide to Ensuring Informed Choice for Individuals with Disabilities. Retrieved August 14, 2020, from https://www.communityinclusion.org/pdf/TO31_F.pdf

Dignity of Risk: Balancing Choice and Risk

What If...You never got to make a mistake?
What If...Your money was always kept in an envelope where you couldn't get it?
What If...You were never given a chance to do well at something?
What If...You were always treated like a child?
What If...Your only chance to be with people different from you was with your own family?
What If...The job you did was not useful?
What If...You never got to make a decision?
What If...The only risky thing you could do was to act out?
What If...You couldn't go outside because the last time you went it rained?
What If...You took the wrong bus once and now you can't take another one?
What If...You spent three hours every day just waiting?
What If...You grew old and never knew adulthood?
What If...You never got a chance?

There are times when you may need to balance safety with the person's dignity of risk. Dignity of risk is the idea that self-determination and the right to take reasonable risks are essential for the person's dignity and self-esteem; and so should not be impeded by caregivers who are concerned about their responsibility to ensure health and welfare.[21] People with disabilities often have less control over risk-taking than those without disabilities, resulting in them missing out on opportunities to learn about their own limits and how to balance risk within their lives. Instead of avoiding risk altogether, people should be supported in having opportunities to experience different options which may include some level of risk. While positive risk taking can have many positive effects on people, overprotection can lead to a myriad of negative, unintended consequences.

[21] Centers for Medicare and Medicaid Services (2019). Balancing Choice & Risk [PowerPoint Slides]. Retrieved from https://www.medicaid.gov/sites/default/files/2019-12/balancing-risk-choice_0.pdf

Positive risk-taking can lead to:

- Improved autonomy, independence, social interaction, and health
- Opportunities for personal growth and learning
- Self-determination and feelings of worth

Overprotection can lead to:

- Feelings of being patronized, smothered, or diminished
- Individuals not being able to reach their full potential
- Loss of self-esteem and worth

The negative feelings that can result from overprotection have the potential to cause people to act out and/or display difficult behaviors in an attempt to let those around them know how bad things have become. In turn, "we respond by attempting to control the behavior, we make judgments that people are not ready for any more autonomy (risk) and we end up creating an ever-downward spiral where the person experiences more harm from our interventions than they ever would have from taking the risk in the first place."[22]

"We can say 'We will protect you and comfort you and watch you like a hawk!' Or we can say, 'You are a human being and so you have the right to live as other humans live, even to the point where we will not take all dangers of human life from you.'" – Robert Perske

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The person's Person-Centered Support Team (PCST) may not always agree with the person in terms of what goals, choices, and activities should be pursued due to concerns over health and safety. In your role as a facilitator of PCP, you will need to mediate these differences of opinion while finding a balance between positive risk taking and ensuring the safety of the person and their community. The opportunity to make mistakes must be balanced against how much

[22] BlueCare Tennessee, Amerigroup (2019). Making Personal Growth and Dignity Possible: Adopting a New Approach to Risk [PowerPoint slides]. Retrieved from https://bluecare.bcbst.com/forms/Provider%20Information/ECF_CHOICES_Provider_Training_Day_3.pdf

understanding of the consequences or degree of harm that may come to the person or others by making a poor choice.

When there is disagreement between the person and the PCST, encourage and support the person in expressing why the goal, activity, or choice is meaningful to them. The PCP discussion should incorporate the choice that raises concerns including:

- Why the choice is important to the person
- The potential risk(s) for the person
- The potential benefit(s) to the person
- The alternative(s)[23]

After the person and the PCST have discussed the choice in question, you should assess the risk and consider potential ways of mitigating it. In collaboration with the PCST, discuss how to minimize the risk(s) and the best approach to supporting the person with their choice given the level of risk that remains. If a person decides to take an informed risk, you should document that taking the risk was part of their plan and that steps were taken to minimize the risk.

When there is a high probability that a choice will result in harm to a person or others, an obligation exists to:

- Be proactive in identifying the cause for concern
- Provide the person with information about the possible consequences of their choice
- Negotiate an agreement with the person that will minimize the possible risk while still respecting the person's preference
- Document the process of negotiation and, if no agreement can be reached, the lack of agreement and the decisions of the parties involved[24]

[23] Centers for Medicare and Medicaid Services (2019). Balancing Choice & Risk [PowerPoint Slides]. Retrieved from https://www.medicaid.gov/sites/default/files/2019-12/balancing-risk-choice_0.pdf

[24] Harken, G., Nelson, B., Schwanke, L. (2016). Finding "Right" in HCBS Services [PowerPoint Slides]. Retrieved from https://www.iowaproviders.org/assets/docs/regional_rights_restrictions_responsibilities.pdf

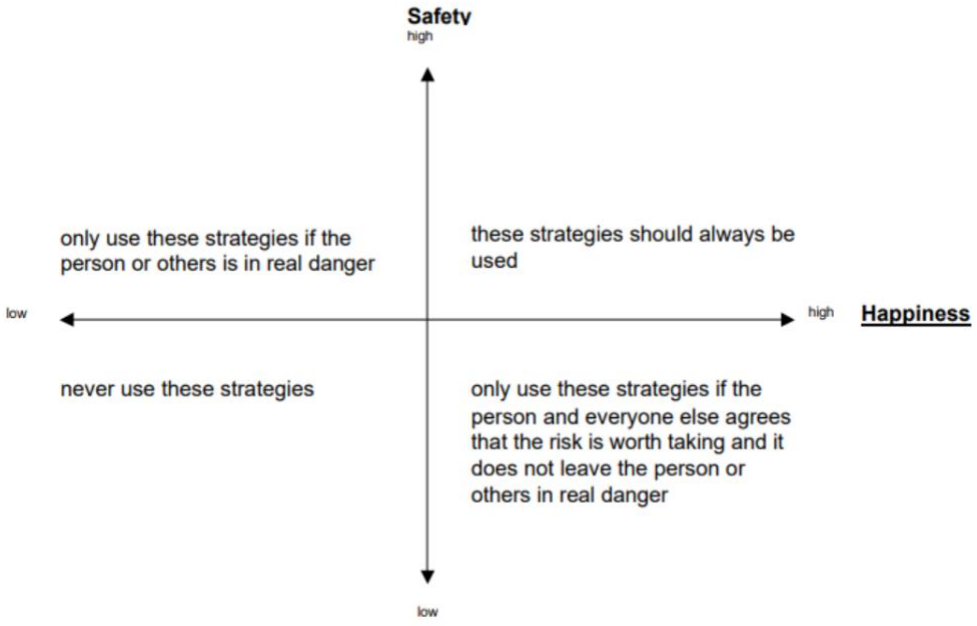


Image credit to: Kinsella, P. (2000). Person Centred Risk Assessment. *Liverpool: Paradigm*.

Occasionally, things may go wrong and the person or someone around them is unforeseeably harmed due to the risk that the person took. If this happens, reflect on what happened and what you learned as a result of it; gather information from the PCST about what occurred; and plan how to move forward using the knowledge gained about the person and the situation. It is important to remember not to be deterred from allowing other people to engage in positive risk taking just because it was unsuccessful in this particular instance. Additionally, just because a person made a mistake, or the risk they took resulted in a negative outcome, it does not mean that they should never be allowed to try again. The person's level of risk can change with time or new circumstances, and should be re-evaluated.

Video Resource

Max Barrows from Green Mountain Self-Advocates describes the concept of dignity of risk: https://www.youtube.com/watch?v=LUka52lKtdw

- Questions to consider while watching the video:
    - What is the key philosophy behind the dignity of risk?
    - Why is the dignity of risk important to people with disabilities?
    - What are the benefits to people with disabilities of having the dignity of risk?

Individual Rights

As outlined in the Settings Rule, all people, including those with disabilities, have certain rights. These rights include, but are not limited to:

- *Privacy:* The person can be alone if they want to and can decide when and with whom to share spaces, conversations, and information.
- *Dignity:* The person has self-respect, is respected by others, and is treated like someone that has value and worth.
- *Respect:* The person is treated with kindness and consideration by others.
- *Freedom from coercion:* The person does not have to do things that they do not want to do.
- *Freedom from restraint:* The person cannot be held against their will, including physical restraints and other types of restraints, such as withholding access to food or personal items.

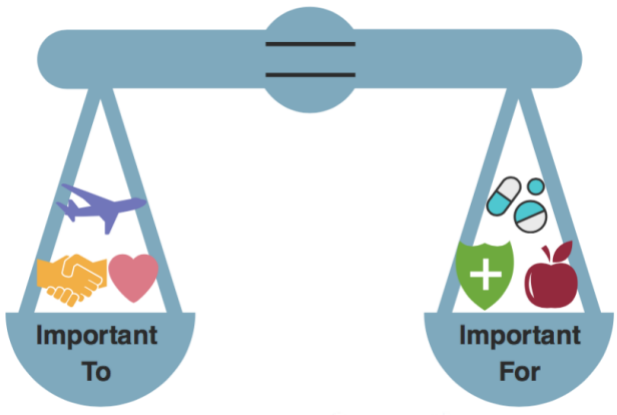
Balancing What is Important To and For Individuals

"Addressing issues of health & safety (Important For) should never be done without equal consideration for being happy and fulfilled (Important To)."
Michael Smull

When we consider what is important *TO* a person, we think about those things in life that will help the person be satisfied, comforted, fulfilled, content, and happy from their perspective. This includes a person's goals, passions, and interests. We take into account relationships, beliefs, hobbies, things to do, places to go, things to have, and routines that matter to them. What is important to a person includes what matters most to them, by the person's definition. Examples of what is important to a person could include having a close group of friends, being employed, making meals for oneself, going to college, watching specific television shows, being married, having a home of their own, sleeping in on weekends, intimacy, etc.

When we consider what is important *FOR* a person, we think about issues of physical and emotional health and safety, including the support needed to ensure a person's well-being. We also consider what others see as important to help the person be a valued member of their community. Examples of what is important for a person may include taking prescribed medication, being connected to their community, exercise or physical activity, getting to work on time, etc. When considering what is "important for" people, if it is something that the person is not entirely in agreement with, the person's Person-Centered Support Team (PCST) should strive to fully understand the person's perspective and their preferences. The PCST should consider if what is "important for" the person is truly necessary (not just something that might be good, but that is not actually critical to the person's health and safety or a standard that people generally do not hold themselves to, such as always eating healthy) and to explore alternatives that are more aligned with the person's desires.

It is crucial to person-centered thinking to separate between what is important to and what is important for a person, and find a balance between the two. Although services are often very good at describing and delivering what is important for someone, what can often be missed is what matters to the person. If we want people to address what is important for them, there has to be an element of it that is important to them.[25]



[25] Roehl, Anne. An Introduction to Person Centered Thinking: Making a Difference Now. https://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_191036.pdf . PowerPoint Presentation)

Some questions you should be able to answer about the person include:

- What is important to the person?
- It is important to note that people who have limited experiences may struggle to describe what is important to them and may need to be exposed to a variety of experiences before they can figure this out.
- What is important for the person?
- Is there a good balance between important to and important for?
- Is there anything else that the person, or the Person-Centered Support Team (PCST), needs to know or learn in order to help the person get what is important to them?
- What can other people do to help the person be successful with what is important to them and what is important for them?
    - This question in particular can inform the discussion around what support they may need.

The answers to these questions may change over time as the person progresses throughout their life, and those around them continue to learn more about the person. Regardless, a person's support staff should understand what is important to the person and what is important for them so that they know how to best support the person.

Thought Exercise: Routines, Rituals, and Important To and For

Asking a person to describe the routines or rituals they have can help the person in identifying and describing what is important to and for them. Try it for yourself! Write out a particular routine or ritual that you have step-by-step, such as the process you go through when waking up or getting ready for bed; or celebrating a birthday or particular cultural holiday. What do you do? Then, consider what parts of the process reflect what is important to and for you. You may want to highlight them in different colors. For example, a person may brush their teeth or take a shower when they wake up as it is important for them to maintain their hygiene. They may wait until all of their family has awakened to eat breakfast or dedicate some time to playing with their dog because it is important to them to spend time with their loved ones. Examining a person's routines or rituals can provide a wealth of information!

Communicating with People Who Communicate Without Words

Some of the people you support may communicate without words, or communicate on a limited basis with few words. Communication challenges do not mean that the person does not have anything to contribute to the Person-Centered Planning (PCP) process. They can still make decisions about their lives and lead the PCP process to the extent they desire.

Listen to what the person is telling you through their facial expressions, behavior, and body language; and do your best to interpret what messages they are trying to convey. Those on the person's Person-Centered Support Team (PCST) can also help you learn about the person's unique communication style and how to best communicate with them. At times, the person's PCST may have different perceptions about what the person is trying to communicate. In these situations, you may find it helpful to fill out a "Communication Chart" with the PCST. If a person's communication style may be difficult to describe in writing, consider incorporating pictures or even videos into the communication chart as-needed.

Communication Chart

What Is Happening	*What the Person Does*	*What It May Mean*	*What We Should Do*
Describes the circumstances or environment, including any triggers.	Describes the action(s) the person takes in response to what is happening.	Describes what the PCST believes the person's action(s) mean (thoughts, emotions, etc.) List all interpretations.	Describes what the PCST believes they should do in response to the person's action(s).

You can also ask the PCST other questions to help identify what the person wants:

- What makes them happy?
- What do they not enjoy?
- What do they try to avoid?
- What do they show interest in?

- Would the person like to explore augmentative and alternative communication devices that could help them communicate?
    - Resources:
        - Utah Assistive Technology Program (UATP): https://www.usu.edu/uatp/
        - Utah Center for Assistive Technology (UCAT): https://jobs.utah.gov/usor/vr/services/ucat.html

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Thought Exercise: Communication Chart

Think about a time you experienced a strong emotion: happiness, anger, jealousy, etc. Fill out the Communication Chart based on the emotion you experienced. What happened to make you feel that way? What did you do or say because of that emotion? What did you mean by what you did or said? What did you want others to do in response to your actions?

Having a discussion with a person who communicates without words about what they want their "good life" to look like may involve some vocabulary that people with limited communication have not encountered much. Individuals who use alternate forms of communication are often exposed to a lot of nouns, things to ask for and to point to, but they are not often exposed to describing words, especially words that could be used to describe themselves, their strengths, dreams, and feelings. They also may not be familiar with the vocabulary we use to talk about employment, adult life, and navigating the community. In addition, they may not have a lot of experience talking about what they DO NOT want because they are reinforced for requesting things, but not necessarily reinforced for rejecting things. Additionally, people with alternative forms of communication may have little or no experience with self-expression in general. They may not really know what it looks and feels like to share their own personal thoughts and feelings. These are all things we need to be aware of and start thinking about, "What words will this person need to participate in this process and how can I teach these words to them?"

There are a lot of different ways that people who communicate without words can choose words to give input in the PCP process. If they have voiced or signed speech, we can teach new words.

If they don't have voiced or signed speech, we can often get a lot of good communication with a simple "Yes'' or "No." Pointing is a great option for many people. If a person does not reliably point, but maybe just bats at things or swipes instead, then actually picking up an item and exchanging it may work better. If reaching and pointing is not reliable, then eye gaze (or pointing with your eyes) can work well. Another strategy for people with complex motor challenges that make the other access methods difficult could be partner assisted scanning. In partner assisted scanning, the person's communication partner presents options one at a time either visually, verbally, or both; and gives the person time to indicate a "yes" or "no" to each option as it is presented. For example, a person may raise his eyes to indicate "yes" and do nothing to indicate "no."

One challenge of getting input from people who communicate without words may be how to represent certain concepts to them in a way that they can understand. Sometimes, actual pictures may be easier understood than symbols, or videos may be easier than pictures. As part of the pre-planning process, you may want to ask the person's Person-Centered Support Team (PCST) for assistance in creating photo albums of the person engaged in activities that they love, and then refer back to these photo albums when talking about their plans for the future. You may also want to consider using "choice cards" which represent ideas; and then have the person prioritize the cards somehow as you work through the PCP process.

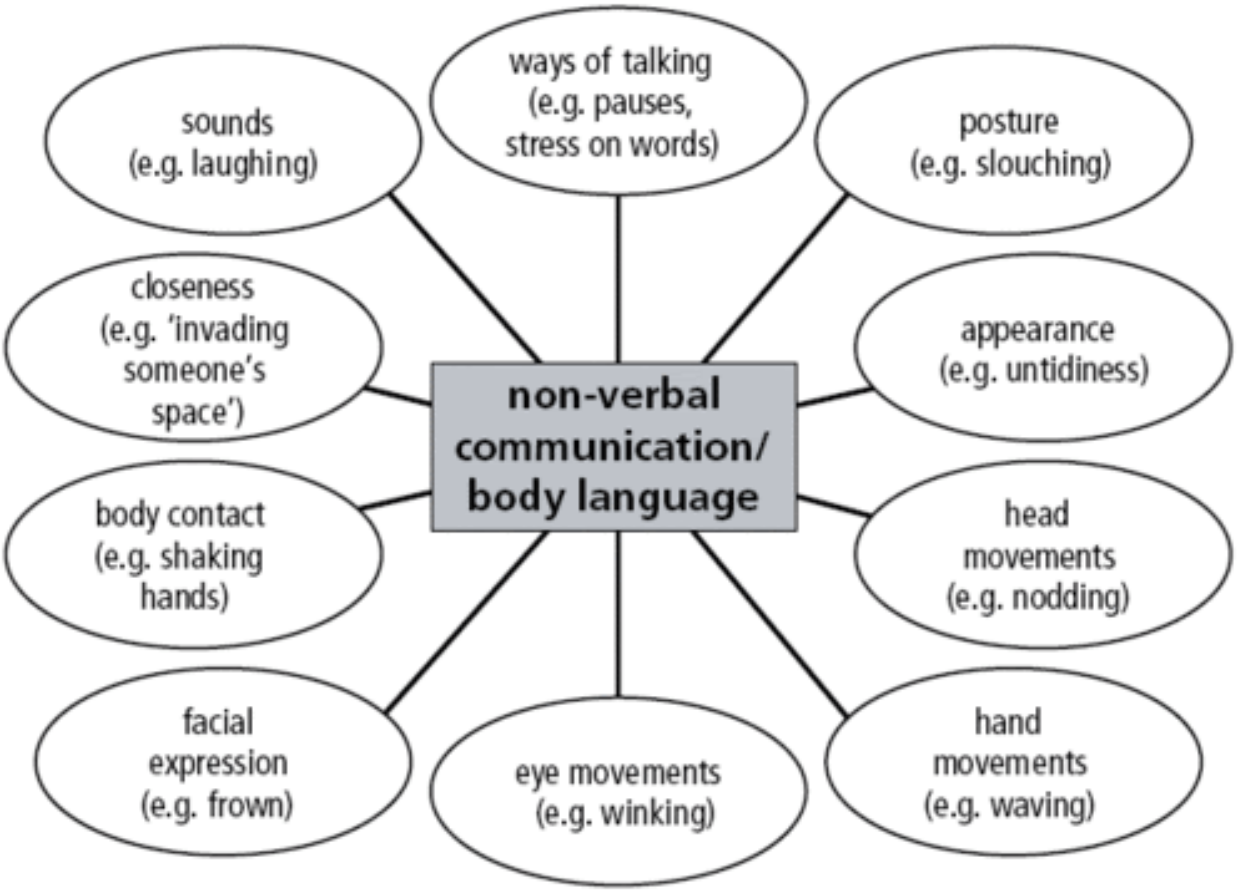
Video Resource

- Beth Mount speaks about how art can be utilized in the PCP process as a form of universal language to communicate ideas: https://www.youtube.com/watch?v=mR_bxs3RhE0

Thought Exercise: Silent Movie

There are many different ways that people communicate without words. Individuals can communicate through eye, hand, and head movements; their appearance and posture; sounds; their proximity to someone else in the room; body contact; and facial expressions.

Silent movies tell a story without words and rely on actors' body language and facial expressions to convey what they are feeling to the audience. Write out a scene for a silent movie while considering what direction you would give to the actor(s) in terms of how they would express what was happening in the plot. If something is difficult to communicate without words, think about how you may want to incorporate drawings or cards with words in your scene. Once completed, you may want to try and act out the scene for another person. Do you feel that you were able to adequately express the scene without words? If not, what would you change, or what additions to the scene could help convey the message?

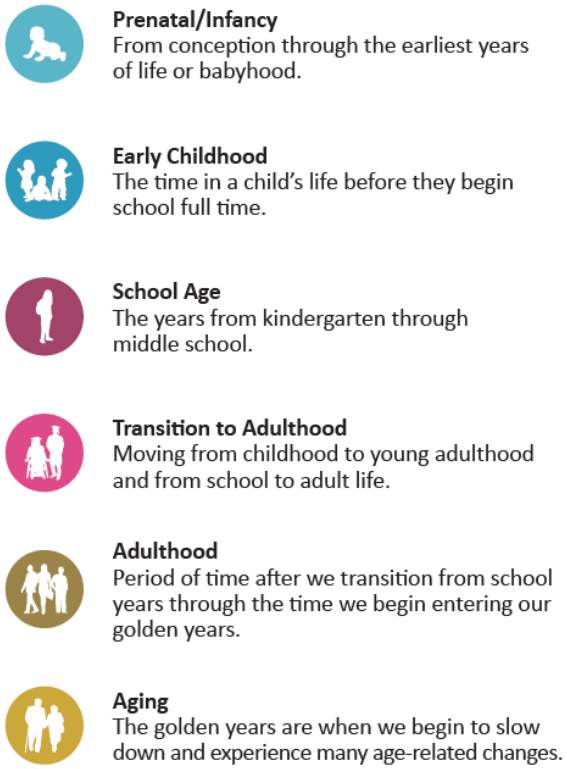


[26]

[26] Source unknown.

Charting the LifeCourse (CtLC) Framework and Life Stages

Charting the LifeCourse (CtLC) is a framework that was developed to help people with disabilities at any age or stage of life think about what they need to know, identify how to find or develop supports, and discover what it takes to live the lives they want to live. People may focus on their current situation and stage of life but may also find it helpful to look ahead to start thinking about what they can do or learn now that will help build an inclusive productive life in the future.[27] DSPD uses the CtLC framework to support the implementation of person-centered planning and practice. Specifically, DSPD emphasizes the principles of Life Stages and Life Domains to support planning that is holistic, and focused on thinking about the present and the future. DSPD uses certain tools from the CtLC library that allow for "operationalizing" the concepts and philosophy explained in this guide. DSPD supports CtLC's core belief that all people and their families have the right to live, love, work, play and pursue their life aspirations just as others in their community do.



The CtLC life stages are: prenatal/ infancy; early childhood; school age; transition to adulthood; adulthood; and aging. CtLC is designed so that people can focus on a specific stage, while keeping

[27] Charting the LifeCourse™ is developed by the Charting the LifeCourse Nexus - LifeCourseTools.com housed at the University of Missouri–Kansas City Institute for Human Development, Missouri's University Center for Excellence in Developmental Disabilities Education, Research and Services (UCEDD).

an eye to the future; helping them know what's coming, what to expect and how to plan for success in the life stages still to come. Throughout childhood and youth, skills and habits can be learned and practiced to realize a vision for a quality of life in adulthood.

CtLC supports reflection and conversations that are focused on the viewpoint of the person with a disability and the ongoing growth to an adult who is self-determined, autonomous and independent.

- In infancy and early childhood stages, the person with a disability asks questions about what the family or others around them are doing to support them or helping them learn to do.
- As the child ages, beginning in youth, transitioning to adulthood, and as an adult, the questions are about what they themselves want or the things they would like to focus on.

Charting the LifeCourse (CtLC) Domains

*All language in the following section has been taken directly from the Charting the LifeCourse framework at: https://www.lifecoursetools.com

People lead whole lives made up of specific, connected, and integrated life domains that are important to a good quality of life. These include daily living and employment, community living, safety and security, healthy living, social and spirituality, and advocacy and engagement. Life domains are the different aspects and experiences of life that we all consider as we age and grow, such as daily life, community living, and healthy living. Everyone has to figure out: what they are going to do during the day – go to school, volunteer, get a job; how they are going to stay healthy and safe; and so on. Person-centered planning includes what is important to and for a person in all life domains; not just health and safety. The life domains support the PCP process in thinking about and planning for life experiences, not just services and supports.

DSPD's use of the CtLC life domains represents a belief in the whole person being important for person centered thinking and planning. DSPD believes that by thinking about the person in each of the life domains, there is an increased probability of developing a comprehensive view of the person that is more likely to include who the person is and what they are about. Developing this broad-based view of the person will then lend itself to helping develop plans that are in line with helping the person move toward, and reach their most desired life.

Daily Life and Employment

The Daily Life and Employment domain encompasses what a person does as part of everyday life such as school, employment, volunteering, communication, routines, life skills. During the early years, the focus is on getting a child ready for school. During the school years, the focus begins to turn to getting ready for adult life – working toward a vision of what the person will do after school ends, what kind of job they might have, and what their day-to-day life might look like. As people age, they may have a desire to retire from work or essentially "retire" from day programs and other structured parts of the service system while focusing their vision elsewhere.

Community Living

The Community Living domain encompasses where and how someone lives including housing and living options, community access, transportation, home adaptations and modifications. Young children usually live with their families. As they leave school, the young adult and/or their family may want to change their living situation, perhaps attending college and living in a dormitory, or getting an apartment with a friend. Depending on the person's culture, they may want to remain living in their home until they are married or have children. Whatever the case may be, learning skills and having responsibilities will help the person prepare for living life as an adult in the way the person and their family envisions!

Safety and Security

Life can be unpredictable and unexpected despite our best efforts. The Safety and Security domain encompasses staying safe and secure and considers emergencies, well-being, guardianship options, legal rights and issues. It is important to find a balance between helping someone stay safe and enabling them to make their own choices and decisions, and even learn from making occasional mistakes! You don't want to give a person so much support and protection that they are unable to have any control of their own life. There are many skills that can be learned and practiced by children and adults that will assist them in being safe, secure and supported while being as self-determined as possible.

Healthy Living

The Healthy Living domain encompasses managing and accessing health care and staying well, including medical, mental health, behavior, developmental, wellness, and nutrition. Living a healthy lifestyle and learning healthy habits begins early and continues throughout the life course. Health and wellness is very important because it can positively or negatively affect other parts of a person's life, such as their ability to go to school or work, live as independently as possible, go places and participate in the community, and associate with family and friends! People with disabilities may experience more health-related issues compared to the general population. Person-Centered Planning should consider how the person can maintain their health. As children begin to transition to adult life, they begin to start taking control of their own health care to the best of their ability. This may mean making healthy choices in what to eat or exercise. It might also mean taking control of or more actively participating in medications, doctor's visits, and other health care decisions.

Social and Spirituality

The Social and Spirituality domain focuses on building friendships and relationships, leisure activities, personal networks, faith, and community. Having friends and personal connections in one's life is key to having a happy and successful adult life. Friends and connections that children make during early and school years – at school, in community activities such as scouting or sports, or in their faith community – have an impact on their adult life. Those school or neighborhood friends may end up being future employers, neighbors, business owners, and most importantly, friends in adult life!

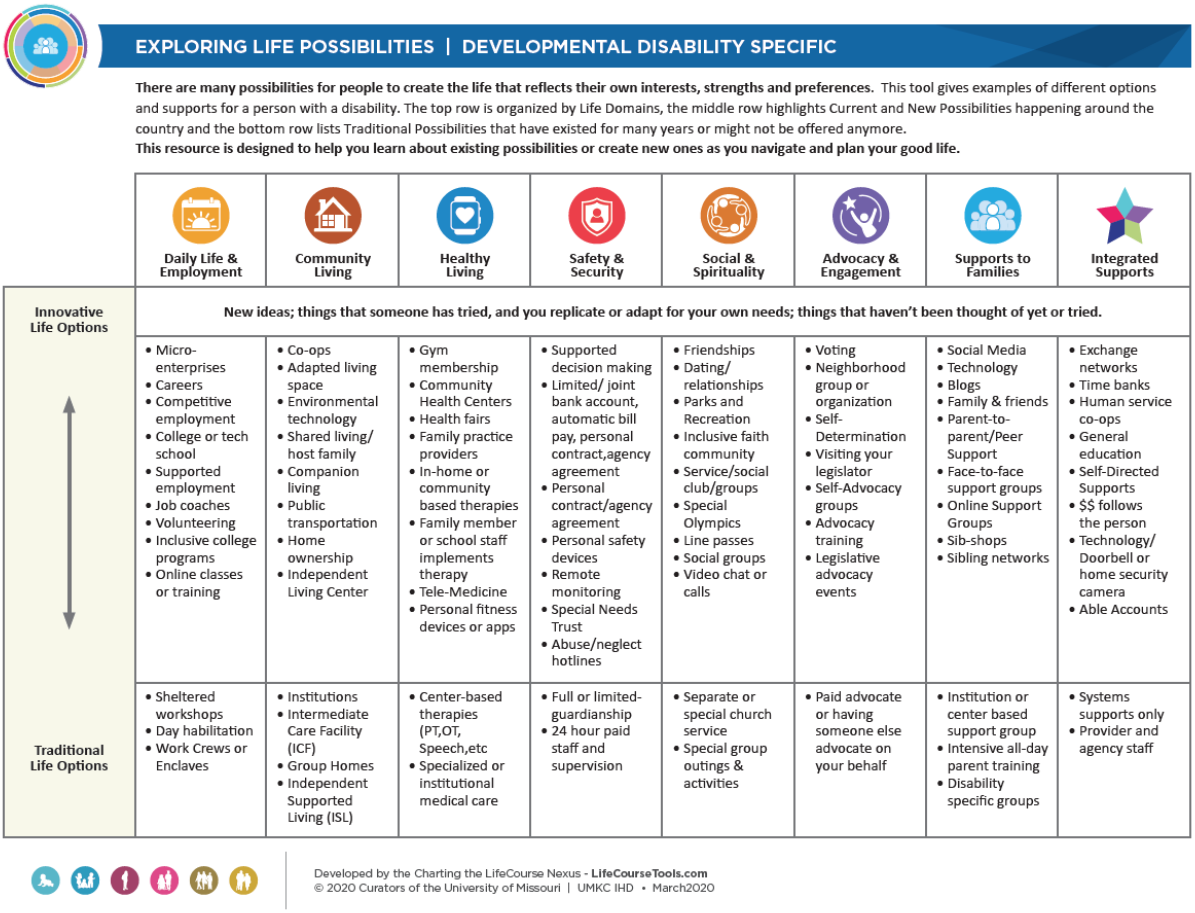
Advocacy and Engagement

The Advocacy and Engagement domain focuses on building valued roles, making choices, setting goals, assuming responsibility and driving how one's own life is lived. Being known and valued in one's community gives a person a sense of worth and of being a contributor, not just someone

who needs assistance. Learning to make choices, set goals, and knowing how to speak up for wants and needs leads to being more self-determined in life and essential to becoming an advocate for yourself or others.

Resource: Charting the LifeCourse Exploring Life Possibilities

The Charting the LifeCourse Exploring Life Possibilities resource helps people and families look at a variety of life options in each of the life domains, some of which are traditional or historic and no longer preferred by many, some that are known and tried, but not necessarily the norm, and others that are new or unfamiliar to people, families and professionals. You can download this resource for free on the Charting the LifeCourse Exploring the Life Domains webpage: https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-domains/



EXPLORING LIFE POSSIBILITIES | DEVELOPMENTAL DISABILITY SPECIFIC

There are many possibilities for people to create the life that reflects their own interests, strengths and preferences. This tool gives examples of different options and supports for a person with a disability. The top row is organized by Life Domains, the middle row highlights Current and New Possibilities happening around the country and the bottom row lists Traditional Possibilities that have existed for many years or might not be offered anymore.
This resource is designed to help you learn about existing possibilities or create new ones as you navigate and plan your good life.

	Daily Life & Employment	Community Living	Healthy Living	Safety & Security	Social & Spirituality	Advocacy & Engagement	Supports to Families	Integrated Supports
Innovative Life Options	**New ideas; things that someone has tried, and you replicate or adapt for your own needs; things that haven't been thought of yet or tried.**							
	• Micro-enterprises • Careers • Competitive employment • College or tech school • Supported employment • Job coaches • Volunteering • Inclusive college programs • Online classes or training	• Co-ops • Adapted living space • Environmental technology • Shared living/ host family • Companion living • Public transportation • Home ownership • Independent Living Center	• Gym membership • Community Health Centers • Health fairs • Family practice providers • In-home or community based therapies • Family member or school staff implements therapy • Tele-Medicine • Personal fitness devices or apps	• Supported decision making • Limited/ joint bank account, automatic bill pay, personal contract,agency agreement • Personal contract/agency agreement • Personal safety devices • Remote monitoring • Special Needs Trust • Abuse/neglect hotlines	• Friendships • Dating/ relationships • Parks and Recreation • Inclusive faith community • Service/social club/groups • Special Olympics • Line passes • Social groups • Video chat or calls	• Voting • Neighborhood group or organization • Self-Determination • Visiting your legislator • Self-Advocacy groups • Advocacy training • Legislative advocacy events	• Social Media • Technology • Blogs • Family & friends • Parent-to-parent/Peer Support • Face-to-face support groups • Online Support Groups • Sib-shops • Sibling networks	• Exchange networks • Time banks • Human service co-ops • General education • Self-Directed Supports • $$ follows the person • Technology/ Doorbell or home security camera • Able Accounts
Traditional Life Options	• Sheltered workshops • Day habilitation • Work Crews or Enclaves	• Institutions • Intermediate Care Facility (ICF) • Group Homes • Independent Supported Living (ISL)	• Center-based therapies (PT,OT, Speech,etc • Specialized or institutional medical care	• Full or limited-guardianship • 24 hour paid staff and supervision	• Separate or special church service • Special group outings & activities	• Paid advocate or having someone else advocate on your behalf	• Institution or center based support group • Intensive all-day parent training • Disability specific groups	• Systems supports only • Provider and agency staff

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utah department of human services
SERVICES FOR PEOPLE WITH DISABILITIES

Planning Tools

Tools are useful aides to help keep the person at the center of the PCP process. The use of tools is not mandatory. However, using tools can help facilitate conversation and ensure the focus remains on the person. It is important to note that completing the tools for the sake of completing the tools should never be the goal. The tools are designed to help with having interactive conversations and visually organizing thoughts and ideas.

There are many different tools that can be used in the Person-Centered Planning (PCP) process to help you discover, plan for, and assist a person in working toward their vision of a good life and enhance their voice, choice, and control. Tools can be used throughout all stages of the PCP process: pre-planning, during the PCP meeting, and post-planning. Tools can also be modified to meet the style of both the Support Coordinator and the person.

DSPD has identified certain tools to help you in the PCP process:

- Life Trajectory for Exploring
- Life Trajectory for Planning
- Integrated Supports Star
- Integrated Long-Term Service and Support Needs
- Life Domain Vision Tool
- Tool for Exploring Decision Making Supports
- Relationship Map
- Good Day/Bad Day

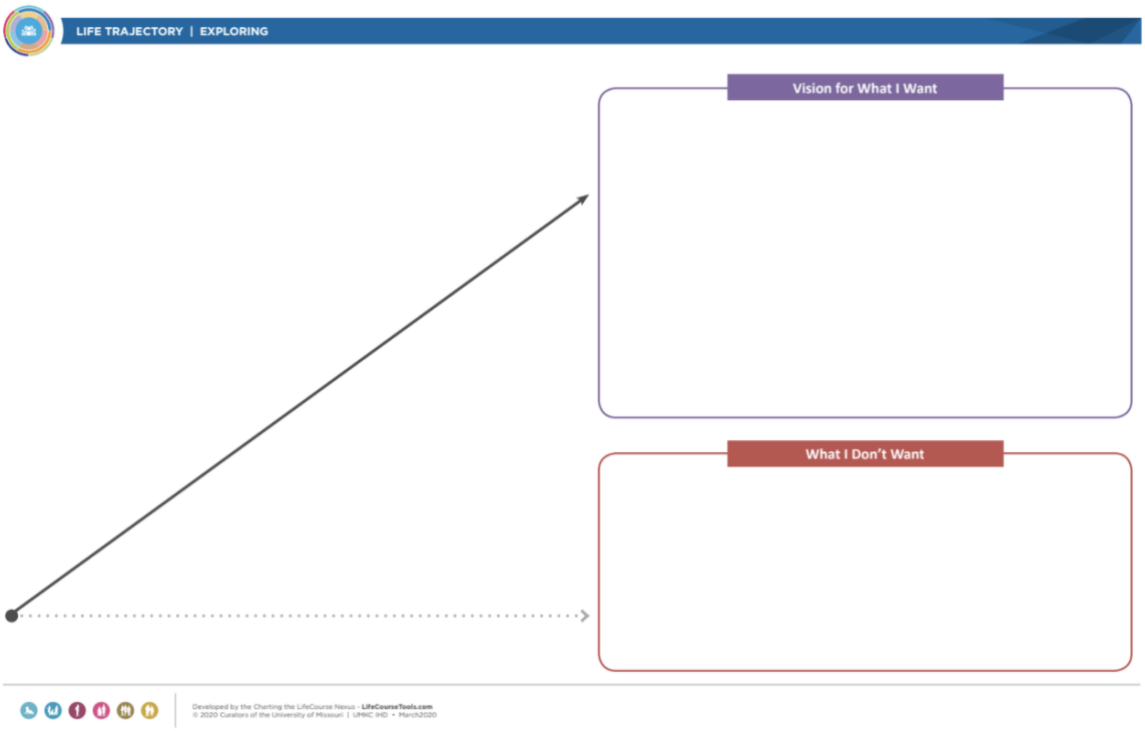
Some Charting the LifeCourse tools include separate versions for the person and their family. While the person's voice and viewpoint must be the driving force of the planning process, other support team members – specifically family members – may also have thoughts and opinions they would like to express. Using separate tools for the person and family ensures that the perspective of all support team members is distinct.

Some of the Planning Tools do not explicitly consider the person's culture and language so it will be up to you as the Support Coordinator to ensure that it is addressed and taken into account.

Life Trajectory for Exploring

The Life Trajectory for Exploring is available to download for free at:
https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/

Life is a journey for everyone. In each stage of life, we are paving a path that leads towards a vision for the future. This path or Trajectory will have ups and downs where there is a need to stop and consider what to do next. The Life Trajectory for Exploring provides space to explore the things going well in a person's life or the things that are stopping them from reaching their good life. This tool is used to facilitate an open conversation about what makes a "good life" and picturing a long-term vision. It also gives us a chance to discuss what the individual does not want in their life and what experiences have occurred that may negatively influence the trajectory to the "good life". The space around the arrows can be used to think about current or needed life experiences that help point the trajectory arrow in the direction of the good life vision.



Video Tutorial on How to Use the Life Trajectory:

https://www.youtube.com/watch?v=58zOH9bvgjc&feature=emb_title

When to Use?

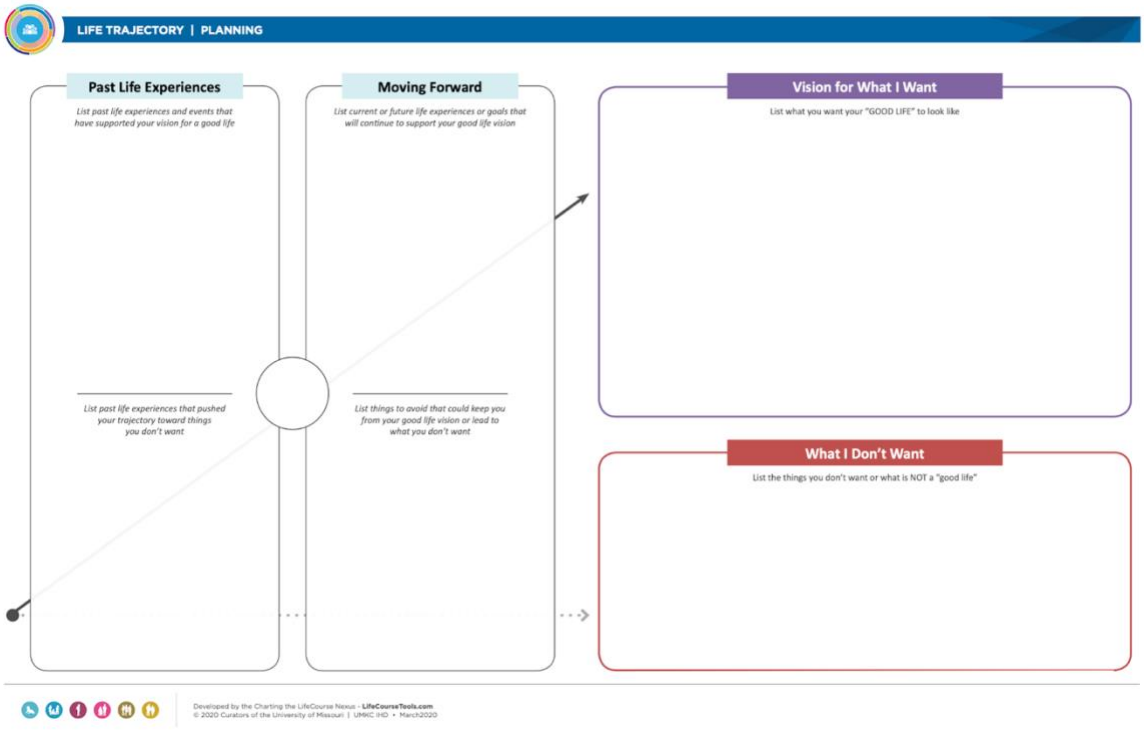
You may find it helpful to use this tool prior to or during a Person-Centered Planning (PCP) meeting in order to get the Person-Centered Support Team (PCST) all on the same page in supporting someone to attain their best life.

Life Trajectory for Planning

The Life Trajectory for Planning is available to download for free at:
https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/

The Life Trajectory for Planning Tool highlights the past life experiences that are leading or moving the person away from their vision and then provides space for current goals and things to avoid moving forward. It helps the person envision their "good life" and identify the steps or experiences needed to get there.

The Life Trajectory for Planning is a visual tool organized in two major sections, *Vision* and *Experiences*. The Vision section, on the right-hand side, is further broken down into what is wanted and what is *NOT* wanted. The Experiences boxes on the left and middle are organized by "past experiences" and "moving forward". This easy-to-use format organizes the information in a way that enables discussion or review of the current and future Trajectory. There is no "right" or "wrong" answer or order to follow when completing the tool. The focus should be on a person's goals, wishes, and desired outcomes.



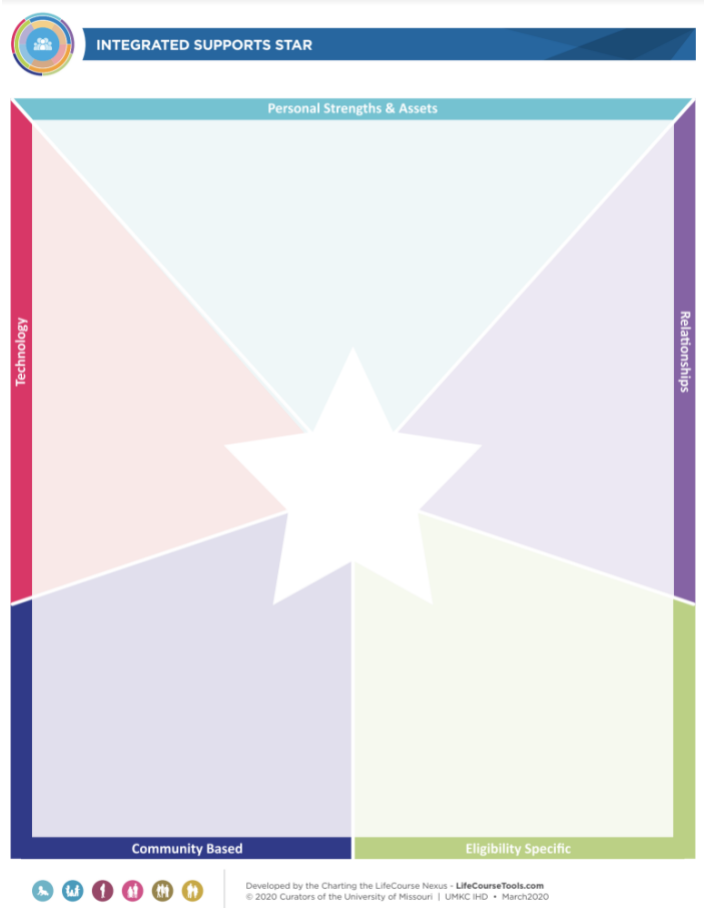
When to Use?

You can use the Life Trajectory for Planning first and then use the Integrated Supports Star to list supports which will help get the person to their vision of a good life. This tool can also be customized to fit someone's specific goal. For example, you may use this trajectory to plan someone's employment goal or goal for living independently. The goals should link to the person's long-term vision of a good life.

Integrated Supports Star

The Integrated Supports Star tool is available to download for free at:
https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/

All people need support to lead good lives. Using a combination of many different kinds of support helps to plot a trajectory toward an inclusive, quality, community life. The star should be used to decide or plan resources based on a person's vision of a good life. The Integrated Supports Star helps brainstorm the support people already have or might need in order to work in partnership to make their vision for a good life possible. The intention of the star is to identify the resources and supports that are available and/or could be developed, and to allow the person to choose the supports and services that make the most sense to them in light of their desired outcome or goal.



In order to support a trajectory to an inclusive, quality, community life, supports for people should be a combination of:

- Personal Assets and Strengths (light blue)
- Relationship Based (purple)
- Technology (pink)
- Community Based (dark blue)
- Eligibility Based (green)

Personal assets and strengths are those things that a person or family brings to the table. It might be tangible resources, or it might be the knowledge, skills, strengths, personality or capabilities of the person.

Relationship-based supports are those things that family, friends, neighbors, co-workers and other people can help with, with the realization that one person probably can't provide all the support a person might need, but several people might each be able to do one thing!

Technology could be anything from specialized technology, personal computers, tablets, smart phones, to something as simple as an alarm clock.

Community-based supports are those things that any community member can access. This might include community centers, grocery stores, public safety, hospitals, parks and recreation, public transportation or faith-based resources.

Eligibility-specific supports include those services or things that someone is eligible to access based on disability, age, income or other specific criteria.

Video Tutorial on How to Use the Integrated Supports Star

https://www.youtube.com/watch?v=yF4RPSnhCag&feature=emb_title

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When to Use?

The Integrated Supports Star is excellent to use before going through the Integrated Long-Term Service and Support Needs Template and figuring out a person's ideal daily schedule. It can also be used as a pre-planning tool with the person and their Person-Centered Support Team (PCST) to identify areas of discussion for the Person-Centered Planning (PCP) Meeting to help save time. The Integrated Supports Star can be used both for mapping current supports to understand what a person has and what may be needed. This can be from a "whole life" perspective or specific to a particular life domain or even a particular issue. It can also be used to plan and support problem solving and decision making around a specific topic, issue, or goal.

Integrated Long-Term Service and Support Needs Template

The Integrated Long-Term Service and Support Needs Template is available to download for free at: https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/

Once you have figured out the types of supports needed and/or those that already exist, this template is a way to apply the supports to a daily/weekly schedule. There are five areas of support identified in this tool, all of which are color-coded for better visual representation of which supports are lacking and which are heavily being used:

- Personal Assets and Strengths (light blue)
- Relationship Based (purple)
- Technology (pink)
- Community Based (dark blue)
- Eligibility Based (green)

Process for Using Long Term Service and Support Needs Template

1. Use the schedule shown below and write in what the weekly schedule currently looks like or what the desired "good day/good week" would look like. Make sure to detail this part as much as possible and include key members, such as families, friends, or staff, to make the most accurate daily schedule. Start with the "why" first - what does the person need or want to do before anything else? What are their desired life activities/experiences? Focus the schedule on when the person needs support, not necessarily when the person is currently receiving support. Supports can then be structured to best meet the person's desires and needs.

   Note: It is also critical to think about a person's skills, strengths and assets as part of this process – start with both what they can do now and what they want to be able to do in the future.

CHARTING the LifeCourse

Integrated Long Term Support Needs

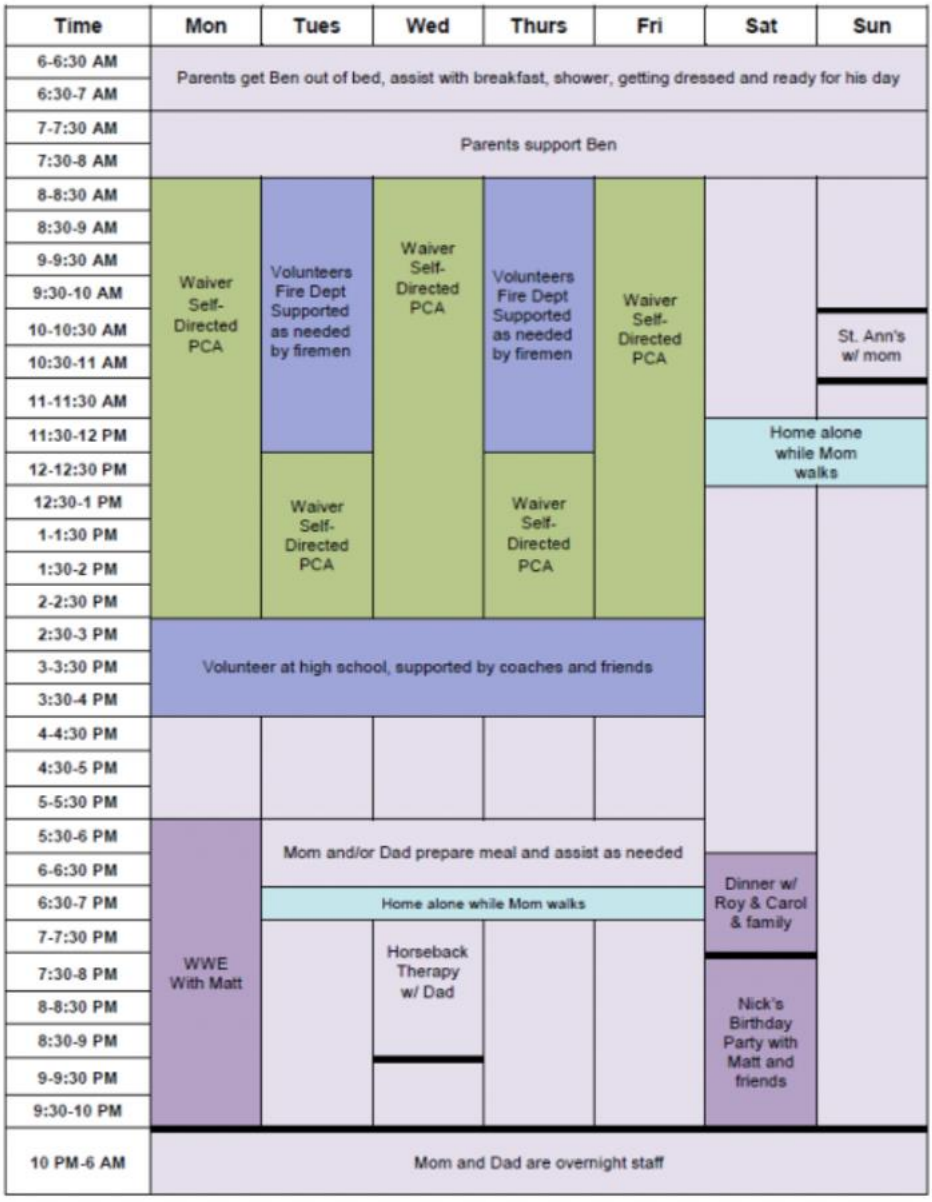
TIME	MON	TUES	WED	THURS	FRI	SAT	SUN
6-6:30 AM							
6:30-7 AM							
7-7:30 AM							
7:30-8 AM							
8-8:30 AM							
8:30-9 AM							
9-9:30 AM							
9:30-10 AM							
10-10:30 AM							
10:30-11 AM							
11-11:30 AM							
11:30-12 PM							
12-12:30 PM							
12:30-1 PM							
1-1:30 PM							
1:30-2 PM							
2-2:30 PM							
2:30-3 PM							
3-3:30 PM							
3:30-4 PM							
4-4:30 PM							
4:30-5 PM							
5-5:30 PM							
5:30-6 PM							
6-6:30 PM							
6:30-7 PM							
7-7:30 PM							
7:30-8 PM							
8-8:30 PM							
8:30-9 PM							
9-9:30 PM							
9:30-10 PM							
10 PM-6 AM							

Developed by UMKC IHD, UCEDD. More materials at lifecoursetools.com MAY 2016

2. Color in each time-slot to the correlating support that is being used. For example, if the person is volunteering at an animal shelter in the community, color in the time-slots dark blue during the time that they will be participating in that activity. You should start with all of the other colors first and then “fill in the gaps” with green (eligibility specific).
3. Notice which colors are lacking and how you could make this schedule more colorful with the person and their PCST.

Note: It is important to follow these steps. There may be a tendency to look at the person's purchased supports and insert them into the support needs (i.e., back into the support array based on existing supports). It is best to identify the needs/desires and then assign supports for those needs/desires. The Integrated Long-Term Service and Support Needs Template can be used in conjunction with the Integrated Supports Star.

An example of what a completed Integrated Long-Term Support Needs worksheet can look like is shown below.



Video Tutorial on How to Use the Integrated Long-Term Service and Support Needs Template

https://www.youtube.com/watch?v=sux0VdmMMkw&feature=emb_title

When to Use?

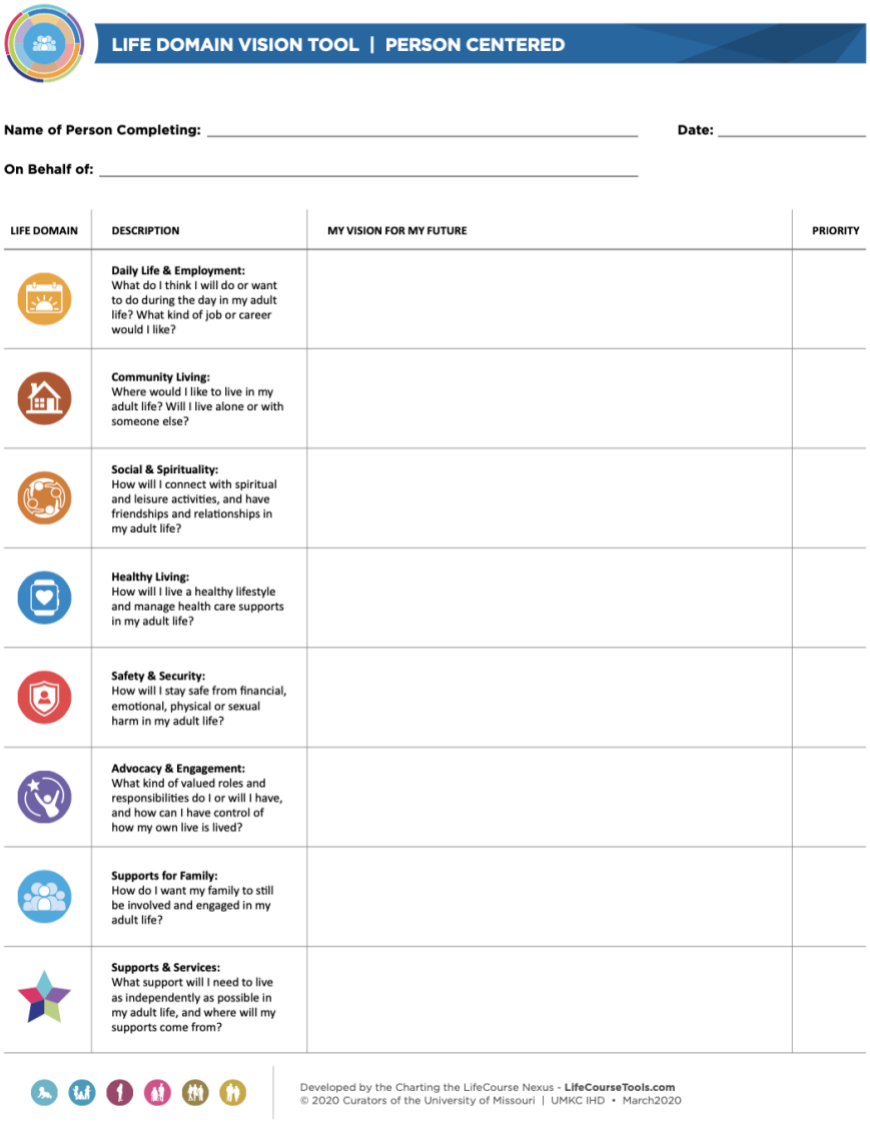
The Integrated Long-Term Service and Support Needs Template can be used when trying to build a typical schedule of supports to meet the person's needs. It can help visualize current supports and identify potential needs and opportunities to further integrate or braid services.

It can also be used for exploring how to maximize the supports that are available. If there are challenges (perceived or real) in meeting a person's needs, this schedule can identify how supports and services may be able to be rearranged to meet those needs. It may also reveal the additional types of supports that should be developed.

Life Domain Vision Tool

The Life Domain Vision Tool is available to download for free at:

https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/



LIFE DOMAIN VISION TOOL | PERSON CENTERED

Name of Person Completing: _____ **Date:** _____

On Behalf of: _____

LIFE DOMAIN	DESCRIPTION	MY VISION FOR MY FUTURE	PRIORITY
	Daily Life & Employment: What do I think I will do or want to do during the day in my adult life? What kind of job or career would I like?		
	Community Living: Where would I like to live in my adult life? Will I live alone or with someone else?		
	Social & Spirituality: How will I connect with spiritual and leisure activities, and have friendships and relationships in my adult life?		
	Healthy Living: How will I live a healthy lifestyle and manage health care supports in my adult life?		
	Safety & Security: How will I stay safe from financial, emotional, physical or sexual harm in my adult life?		
	Advocacy & Engagement: What kind of valued roles and responsibilities do I or will I have, and how can I have control of how my own live is lived?		
	Supports for Family: How do I want my family to still be involved and engaged in my adult life?		
	Supports & Services: What support will I need to live as independently as possible in my adult life, and where will my supports come from?		

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Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full, inclusive, quality life in the community. Charting the Life Course includes Vision tools for both the person and their family. The Utah System for Tracking Eligibility, Planning and Services (USTEPS) application includes the Life Domains and Stages for the person as a base component of PCP. There is also a "Family" version of the tool. The Life Domain Vision Tools help

people of all ages and/or their families start to think about a more specific vision for life as an adult. This tool also helps people and families narrow down what life domain(s) they are focusing on by rating what is most important to them at this point in time. Additionally, comparing the vision of the person with the vision of family members can provide insight for moving in a shared direction or identifying areas of conflict that may need resolution. This tool covers the six life domains of Daily Life & Employment, Community Living, Social & Spirituality, Healthy Living, Safety & Security, Advocacy & Engagement.

The first step to using the tool is to discuss each domain with the person and define what it means to them if necessary, taking into account their cultural context. You may need to provide examples to help the person understand what each domain entails and start thinking about their vision for a future. Then, use the questions listed in the tool and some of your own to further drive the conversation of what each domain will look like at some future point. You may find the Quick Guides in the Life Experience Series useful during this step as each four-page guide contains a few questions from each of the life domains for that specific life stage:
https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-stages/

The next step is to discuss what the current situation is for each domain. Is the person working on finding housing or do they already have a set living situation? Are they employed or want to start taking steps towards employment? Do they already exercise or want to start?

Finally, the person will rank each of these domains in a different priority. Many of these can be labeled as the first priority. For instance, the person may want to start exercising as soon as possible as well as begin looking for a job. What are things we can begin to implement right away versus things that may take a while? For example, the person can start the process of looking for jobs right away, but they may not start actual employment for another two months.

Video Tutorial on How to Use the Life Domain Vision Tool

https://www.youtube.com/watch?v=mR6Gq5JeRCg&feature=emb_title

When to Use?

You may find it helpful to use the Life Domain Vision Tool during the Person-Centered Planning (PCP) meeting to aid in the creation and development of the person's present and future goals. Additionally, this tool can assist people who do not know what they want for their vision of a good life by breaking it down into more concrete chunks that feel less overwhelming. The Life Domain Vision Tool can also help with identifying specific goals and action steps related to the big picture vision of a good life.

Tool for Exploring Decision-Making Supports

The Tool for Exploring Decision-Making Supports is available to download for free at: http://www.lifecoursetools.com/lifecourse-library/exploring-the-life-domains/supported-decision-making/

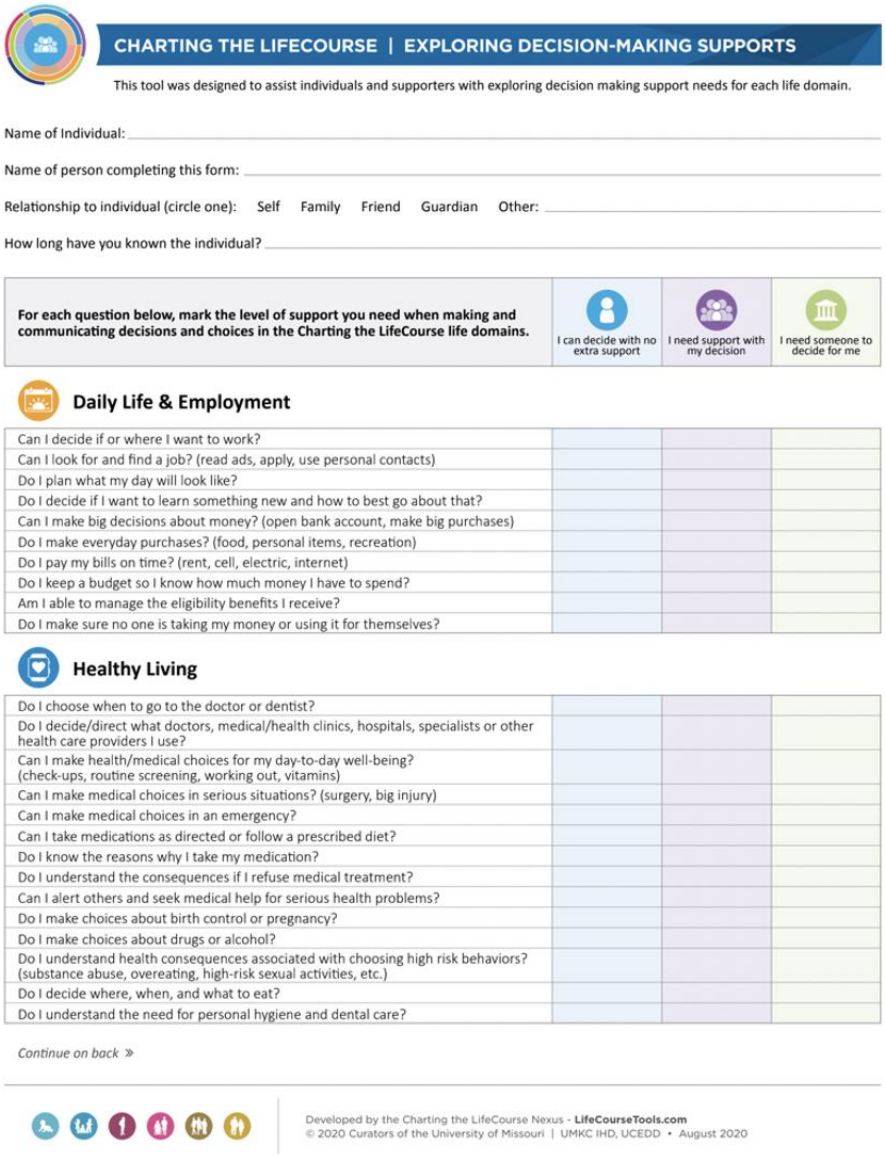
The Tool for Exploring Decision-Making Supports was designed to assist people and supporters with exploring decision-making support needs for each life domain. The tool identifies areas in which a person will, or will not, need personalized supports to make important decisions. The tool identifies three levels of decision-making:

- I can decide with no extra support
- I need (or want) support with my decision
- I need (or want) someone to decide for me

It breaks out the decision levels by life domains, with questions in each area to determine how independent someone is in their decision-making process.

It is important to acknowledge that at times, we all may want and appreciate support from others in our lives when it comes to making certain life decisions. It does not always come down to whether the person can or cannot make the decision without support, but whether or not they want to make the decision without support. This is an important consideration to discuss with the person and their support team when completing this tool.

A sample of the tool follows. Please note that the complete tool covers all six life domains.



CHARTING THE LIFECOURSE | EXPLORING DECISION-MAKING SUPPORTS

This tool was designed to assist individuals and supporters with exploring decision making support needs for each life domain.

Name of Individual: _____

Name of person completing this form: _____

Relationship to individual (circle one): Self Family Friend Guardian Other: _____

How long have you known the individual? _____

For each question below, mark the level of support you need when making and communicating decisions and choices in the Charting the LifeCourse life domains.	I can decide with no extra support	I need support with my decision	I need someone to decide for me
Daily Life & Employment			
Can I decide if or where I want to work?			
Can I look for and find a job? (read ads, apply, use personal contacts)			
Do I plan what my day will look like?			
Do I decide if I want to learn something new and how to best go about that?			
Can I make big decisions about money? (open bank account, make big purchases)			
Do I make everyday purchases? (food, personal items, recreation)			
Do I pay my bills on time? (rent, cell, electric, internet)			
Do I keep a budget so I know how much money I have to spend?			
Am I able to manage the eligibility benefits I receive?			
Do I make sure no one is taking my money or using it for themselves?			
Healthy Living			
Do I choose when to go to the doctor or dentist?			
Do I decide/direct what doctors, medical/health clinics, hospitals, specialists or other health care providers I use?			
Can I make health/medical choices for my day-to-day well-being? (check-ups, routine screening, working out, vitamins)			
Can I make medical choices in serious situations? (surgery, big injury)			
Can I make medical choices in an emergency?			
Can I take medications as directed or follow a prescribed diet?			
Do I know the reasons why I take my medication?			
Do I understand the consequences if I refuse medical treatment?			
Can I alert others and seek medical help for serious health problems?			
Do I make choices about birth control or pregnancy?			
Do I make choices about drugs or alcohol?			
Do I understand health consequences associated with choosing high risk behaviors? (substance abuse, overeating, high-risk sexual activities, etc.)			
Do I decide where, when, and what to eat?			
Do I understand the need for personal hygiene and dental care?			

Continue on back »

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Video Tutorial on How to Use the Tool for Exploring Decision-Making Supports

https://www.youtube.com/watch?v=Vew2Yfk9XiU&feature=emb_title

When to Use?

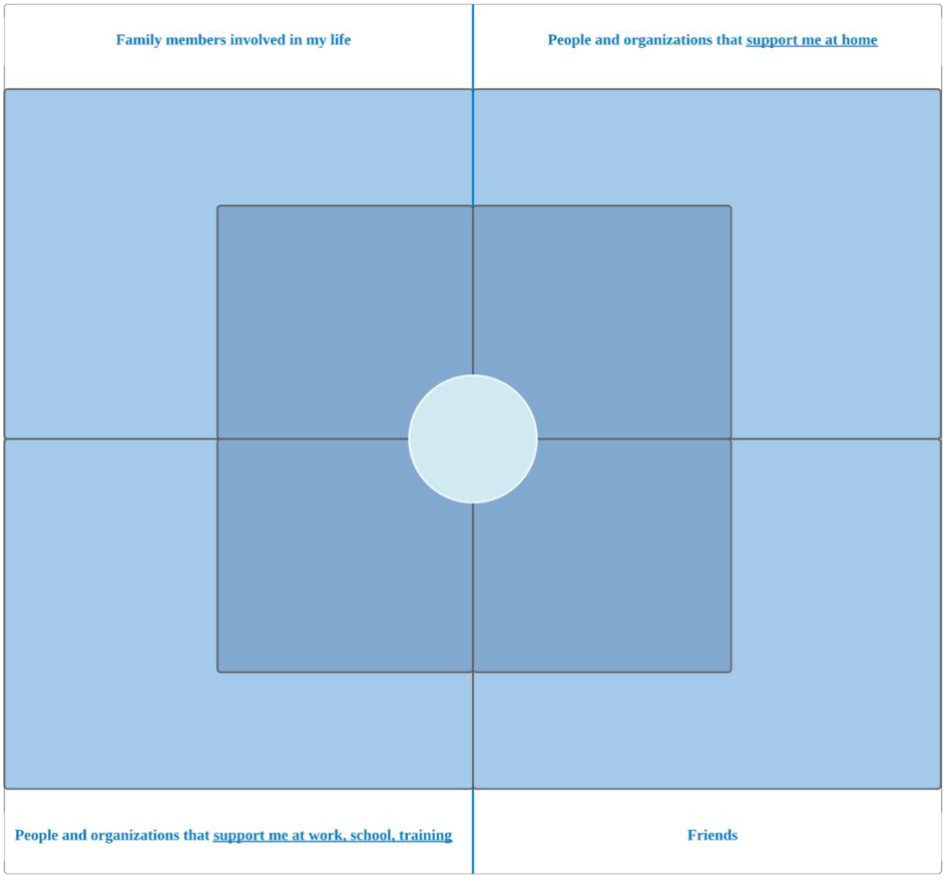
You may find it helpful to use the Tool for Exploring Decision-Making Supports during a Person-Centered Planning (PCP) meeting in order to receive feedback not only from the person, but those who have supported the person in the past in some of these areas with decision-making. It can help with decisions surrounding guardianship and lets caregivers see areas they could step back, or areas where additional training and/or support might be helpful.

Relationship Map

The Relationship Map is available to download for free at: https://dspd.utah.gov/wp-content/uploads/2021/05/Person-Centered-Planning-Relationship-Map.pdf

The Relationship Map assists the person with identifying people in his or her "circle." This tool can be used to help identify who the person would like to be a part of their Person-Centered Support Team (PCST), where a person has solid support or where they may be lacking in support. There are four areas of the Relationship Map:

- Family Members Involved in My Life
- People and Organizations That Support Me at Home
- People and Organizations That Support Me at Work, School, Training
- Friends



Begin by writing the person's name in the center circle. Next, write the names of individuals the person knows and cares about into the map accordingly. Be sure to put those who may have larger, more important roles to the person, closer to the center circle. Indicate the nature of the relationship by the placement i.e.: family, friends, people who help me at home; people who help me at work, school, training, etc. Then, indicate the intensity and strength of the relationship by writing the name closer to the center. Place people who are, or might be, involved in the person's support circle in the inside squares. Some people may be in more than one group.

Finally, look at the map. What do you notice? Do you see any patterns or themes? When the tool is finished, you should be able to easily see where support is solid and where support is lacking. Take time to brainstorm who could fill these gaps and how they could be beneficial to the people you serve. For most of us, having relationships in each area contributes to the life we want.

Video Tutorial on How to Use the Relationship Map

https://www.youtube.com/watch?v=l_JlXsdM_lY&feature=emb_title

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When to Use?

The Relationship Map is a great tool to use in conjunction with other tools, and as a precursor to the Person-Centered Planning (PCP) meeting to make facilitating the meeting easier. As you write names in the squares, you may find it useful to highlight those people who the person wants to have at their PCP meeting as a reference for when you are pre-planning for the meeting.

Thought Exercise

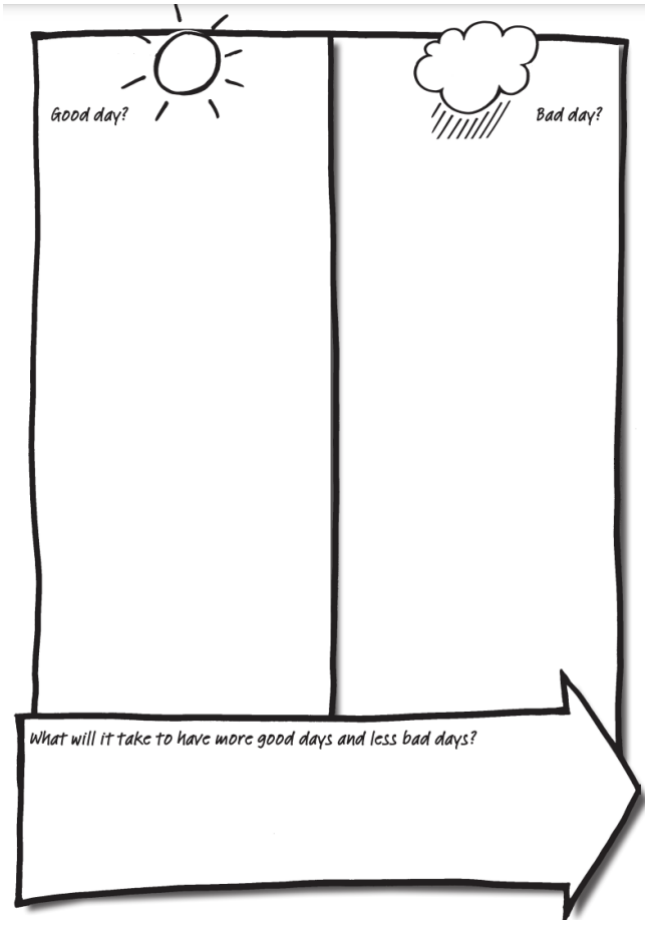
Fill out a relationship map for yourself. List the number of people who are your family members or anyone who is paid to be a part of your life, and then compare that number to the number of people who are connected to you simply because they want to be. What do you see?

Compare your complete relationship map to the relationship map of the person you are supporting. What are the similarities? What are the differences? Does the person have a variety of unpaid relationships in their life comparable to yours? If the person has no, or a very small number of unpaid relationships, how can the person's personal network be built up?

Good Day/Bad Day

Good Day/Bad Day is available to download for free at:
http://www.helensandersonassociates.co.uk/wp-content/uploads/2015/02/gooddaybadday.pdf

The Good Day/Bad Day tool helps you to have conversations about what a good day is like for a person, from when they wake up to when they go to bed. You can then look at the same detailed information for a bad day. Write what makes up a good day for the person in the left-hand column of the tool, and what constitutes a bad day for the person in the right-hand column of the tool. In the arrow at the bottom of the tool, write down what needs to happen in order for the person to have more good days and fewer bad days. The Good Day/Bad Day tool helps you to learn what is important to the person – both what must be present in their day and what must not happen.



When filling out the Good Day/Bad Day tool, some questions you may want to ask the person include:

- Tell me about a happy day.
- Tell me about a sad day.
- It is important to note that you must be prepared to address, and effectively respond to, any historical trauma that the person may bring up when discussing what a sad day looks like to them.
- What makes you excited?
- What bothers you?
- Can you tell me about the times you have the most fun? Who are you with? Where are you? What do you do?

Note: Something you may want to consider is whether a good day or bad day is about the person's routine, rhythm or pace of life - do they like to be busy or prefer a slower place?

Any of these open-ended questions need to be phrased carefully to encourage the person to say whatever comes to mind rather than looking for "the right answer."

When to Use?

The Good Day/Bad Day tool can be helpful to use when determining what is important TO a person. Information about what makes up a good day for a person can also be used when deciding what services and supports the person may need.

If a person is new to you and you have not spent much time with them, you may find it helpful to complete this tool early in the planning process to break the ice and get them comfortable with sharing personal information.

Employment Planning

"Employment is a natural course of adult life and provides the person with a chance to grow financially, contribute to society in a meaningful way and build self-esteem. We must start from the point of view that all people, no matter what their abilities can benefit from having the opportunity to work."[28]

Person-Centered Planning for employment is interest driven. Employment desires, career potential and overall vocational satisfaction are more important than current skill level or ability.[29] Every person, regardless of disability, is employable in competitive and integrated work. When a person has decided to seek a job in the community, planning for employment helps the support team to identify vocational interests, set goals to achieve gainful employment and address any barriers to employment.

Barriers to finding a job may arise during a job search, such as discrimination on the basis of: disability, age, race, gender, sexual orientation, ethnicity, or culture, etc. Other on-the-job barriers could include: a significant mental health issue, prevalence of an unprofessional behavior, a physical accommodation, or resistance to work from Person-Centered Support Team (PCST) members. If and when barriers arise, Support Coordinators should advocate for the job seeker by: offering current and complete information, addressing action steps, and facilitating solutions, and connecting the person to appropriate state and local resources (such as Vocational Rehabilitation, Disability Law Center, Utah Labor Commission, etc.)

Use person-centered planning tools to identify vocational interests, to assist the person with problem solving, and to ask open-ended questions about a person's knowledge, opinions, and

[28] (2018). Person-Centered Support Plan Instruction Manual. Retrieved from: https://www.apd.myflorida.com/waiver/docs/DRAFT%20Person%20Centered%20Support%20Plan%20Manual%2022818.pdf.

[29] Condon, C., Fichera, K., Dreilinge, D., (2003). More Than Just a Job: Person-Centered Career Planning: Institute Brief 16. Retrieved from: https://www.communityinclusion.org/article.php?article_id=16

feelings about employment. Your role as a Support Coordinator is to champion the person's vocational desires and advocate for the most appropriate community-based employment outcome. Advocacy should continue until the person, family members, and providers all reach agreement on a plan to address a barrier to employment.

Competitive Integrated Employment

Competitive Integrated Employment (CIE) means that people with disabilities are able to work in the community alongside people of all abilities; are employed by a non-service provider setting or business; are compensated at or above minimum wage or comparable to people without disabilities who work in the same place and perform the same or similar work; and have access to opportunities for advancement and benefits.

As an Employment First state, Utah prioritizes CIE as the first and preferred employment outcome for people with disabilities. DSPD's mission is to ensure our services emphasize, support and promote CIE, allowing every person with a disability to achieve their career potential. For this reason, when we refer to "work" or "employment" in this manual, we are referring to CIE unless identified otherwise.

Where to Start?

Finding a job in a community setting is the first and preferred expectation for all youth and adults. We specifically discuss employment in Person-Centered Planning to ensure people have equal access to employment without exception. If a person's interests, desires, and passions are inaccurately identified during the planning process, support teams are less likely to find and maintain the right job for the person. Gathering information from all settings, sources and experiences can bring unknown vocational interests to the surface and identify an existing social and professional network. More information about the person equals a better job match for the person. Multiple observations in both familiar and unfamiliar community settings is best practice. You can discover valuable information regarding the person's employment interests by observing

the person in any activity. Some tools to gather this information could include: the DSPD Employment Pathway Tool and the SELN: Guidance for Conversations.

In an effort not to repeat questions or add planning steps, collect as much information as possible prior to starting a guided conversation about employment. Information on employment interests may occur as a result of the use of any person-centered planning tool.

DSPD Employment Pathway Tool

Guided employment conversations with people should occur regardless of perceived barrier or significance of support needs. The intention of guided employment conversations is to ensure information, options, and experiences are offered to the person prior to any decision about CIE. DSPD has created an Employment Pathway Tool which outlines a step-by-step process for holding a guided employment conversation. It includes general information-gathering questions, specific employment directed prompts, and suggested next steps for Person-Centered Planning and Vocational Rehabilitation (VR). Information gathered while completing the steps of the tool may also be helpful in other areas of the PCP process. The guided employment conversation should occur at least annually.

Focused goals and activities that address hands-on informed choice experiences represent one result of the DSPD Employment Pathway Tool. If the person, after the guided conversation, chooses not to seek CIE right now, the goals and activities should emphasize community-based skill building activities. When a person is passive about employment, help the Person-Centered Support Team (PCST) identify purposeful activities connected to interests and desires. The degree of interest in CIE may change in each life stage. Individuals and families can prepare for work early by developing job skills, setting employment goals, assuming competence, and valuing community work as an expectation. As exposure to employment possibilities continues, update decisions about employment utilizing the DSPD Employment Pathway Tool.

Please use professional judgement when determining whether seeking employment is the best option for the person right now. If the person is experiencing a critical medical issue, a significant mental health concern, or other barrier to employment, address this support need as a step toward CIE. In these situations, Support Coordinators should ensure the person has informed choice and set goals that lead to medical, behavioral, mental and vocational stability.

Planning Tool Tip

Charting the LifeCourse has an Experiences and Questions booklet to further explore what people and families need to know and do at each life stage when considering employment: https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-stages/

Vocational Rehabilitation (VR)

If the person is interested in securing work, balancing when and how to utilize Vocational Rehabilitation (VR) is essential. You should view VR as a resource and partner in securing and maintaining a successful CIE outcome. Some supports offered through VR are similar to DSPD, while other services vary in design and available funding. As long as the services do not overlap, support coordinators should utilize DSPD and VR services together to support a person in a job placement, training program, or education.

While a person is accessing VR services, coordination of care between VR and DSPD will ensure long-term vocational success. Employment goals, supports strategies, and activities in the PCSP should support any authorized VR services.

Implementing Employment Supports

Depending on the person's situation, securing CIE could occur within a few months, the next plan year, or years in the future. Success in work settings involves more than just completing vocational tasks and assignments. Work also requires: effective time management, an ability to follow instructions, interpersonal soft skills and many others. Support Coordinators should consider during planning how all supports impact the person's ability to maintain work.

For new job placements, it may be difficult to know the exact level of employment supports needed. In this situation, prescribing employment services for smaller amounts of time is advised until some level of workplace stability is reached. The service delivery approach for employment should always create opportunities for future independence. Developing natural supports in the work setting is one strategy to allow for eventual fading of direct service interventions. Natural supports could include: family members, friends, coworkers, mentors, community members and others. During PCP meetings, consider if changes to employment supports could create an opportunity for: promotion, development of a new work skill or research of a different vocational interest.

Video Resource

View the video on this webpage: https://www.thinkwork.org/vermont-self-advocates-video

How does the support team presume competence in competitive integrated employment during pre-planning, the PCSP meeting, goal development, support strategies and service delivery?
What improvements are needed to better promote capability, competence and independence in all areas of the person's life?

Pre-Planning: Preparing for the Person-Centered Planning (PCP) Meeting

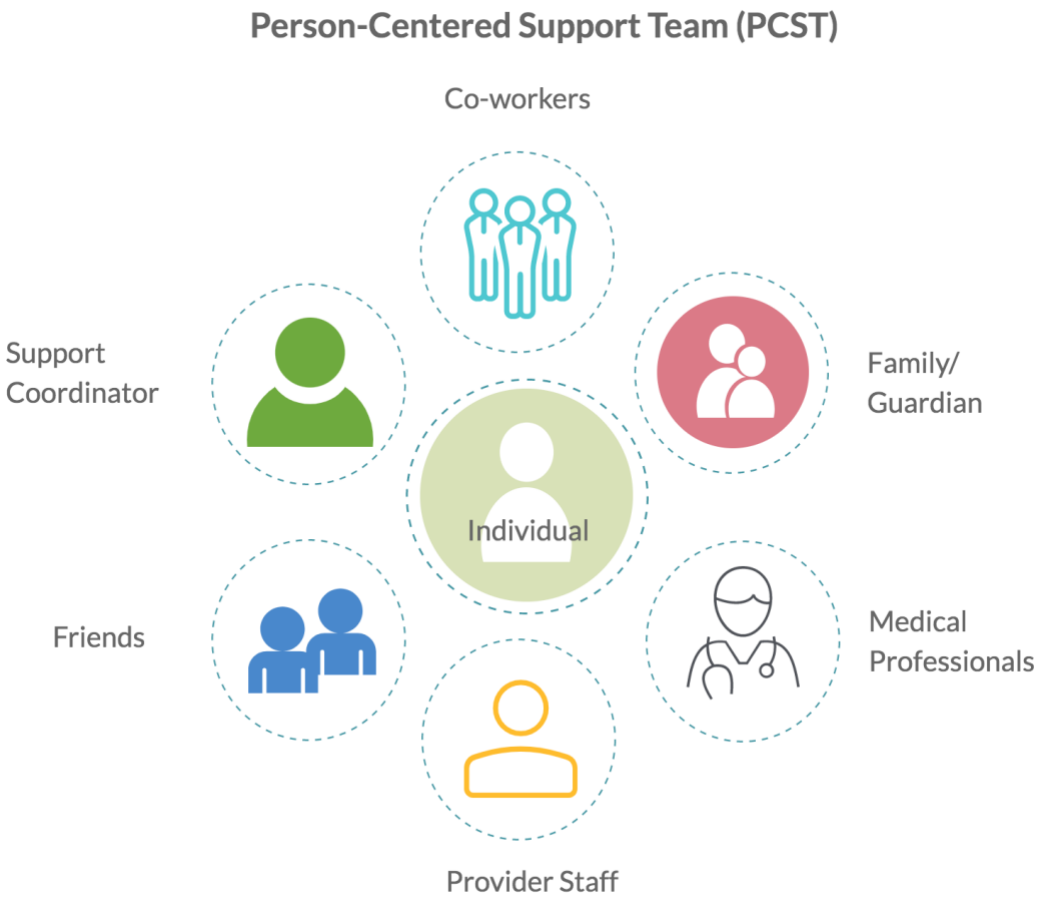
The intent of pre-planning is to gather the necessary resources and information about a person in order to conduct an effective Person-Centered Planning (PCP) meeting. Some of the activities that can be done during pre-planning include identifying who should attend the PCP meeting, preparing an agenda, assisting the person in leading their meeting to the fullest extent possible, and completing some person-centered tools, such as the Tool for Supported Decision Making and the Relationship Map.

Identifying Time, Location, and Who Should Attend

One of the first steps in preparing for the PCP meeting is helping the person identify who they want to invite and participate in their meeting (you may want to use the Relationship Map for this step), and the time and location (physical, virtual, or hybrid) to hold the meeting that would be the most convenient for the person.

The participants of the PCP meeting become the person's Person-Centered Support Team (PCST), and are an integral part of the PCP process. A person's PCST is composed of people chosen by the person, such as the person's Support Coordinator, Service Provider, family, friends, and whoever else the person would like to support them during the planning process.

Members of the PCST are at the planning meeting to strengthen the person's voice in the planning process; support the person to explore their hopes and dreams; encourage opportunities and experiences; and assist the person in making informed decisions. The PCST enables and assists the person to identify and access a personalized mix of paid and non-paid services and supports that will assist them in achieving personally-defined outcomes in the most inclusive community setting. The PCST should also clearly define how they will support the person, and what their roles and expectations are, or will be.



The PCP meeting should occur at a time and location that is convenient to the person. The location should have sufficient privacy, adequate space to accommodate the PCST, be relatively quiet and calm, and be a place that the person feels safe and comfortable in. The location should not risk violation of privacy standards, and be a private place where any exchange of the person's information can reasonably be kept confidential. Given the fact that PCST members may have conflicting schedules, ask the person for multiple times and dates for the meeting so that you can see which time and date would work best for the majority of the PCST.

After the person has decided on a location and some date and time options, you should contact the PCST members at the first of the month to begin coordinating schedules. If necessary, you can make arrangements for a teleconference, or plan to share the information presented in the meeting with any absent PCST members by phone calls or emails.

Some additional questions you may want to consider when preparing for the PCP meeting include:

- How long should the meeting be?
- Should there be one longer meeting, or a series of shorter meetings? What would the person prefer?
- Does the person or anyone on the PCST need any accommodations?
- How should I ask the person and their PCST to prepare for the meeting?
- How does the person prefer to communicate?
- What planning tools will be useful to have at this meeting? (i.e. Charting the LifeCourse tools/other person-centered tools, whiteboard, visuals, markers, etc.)

Preparing an Agenda

Once you have helped the person schedule their PCP meeting, create and send out an agenda for the person and the PCST to review before the meeting. The agenda should be created or outlined with the input of the person to the extent they desire. You should discuss both what the person would like, and would not like, to talk about during the PCP meeting.

Some examples of what to include on an agenda are as follows:

Administrative/Housekeeping Activities

- *Introductions:* introduce yourself, your organization, and your role. Encourage introductions from the person and the PCST, including how they support the person; and any "ice breaker"/ "getting to know you" activities.
- *The intent of the meeting:* what the PCP process will look like and what some of the expected outcomes of the meeting are.
- *Roles:* define the roles of everyone present at the planning meeting. You may find it useful to assign someone to be a notetaker or a timekeeper.

- *Ground rules:* some examples of ground rules could include being respectful, actively listening, or using plain language instead of jargon or acronyms. If anyone breaks the ground rules during the meeting, remind them of what was agreed upon.
- *Facilities:* if applicable, establish where certain facilities can be found in the location, such as a bathroom or a water fountain.

PCP Process Activities

- *Strategies for solving conflict or disagreement within the PCP process*, including clear conflict-of-interest guidelines for all planning participants.
- *Updates:* any important changes to medical, health, and safety issues.
- *Review of last year's goals:* discuss the progress on the person's goals from the past year and celebrate their progress.
- *Set goals for the next year* by asking the person what they want to work on.
- *Develop support strategies.*
- *Schedule or take breaks* accordingly to give the person and the PCST some time to process information and regain focus.
- *Review assessments* including any planning tools that have been completed.
- *Complete additional tools.*
- *Review input* from providers and family.
- *Discuss what is Important TO and FOR the person.*
- *Discuss what the person and what the family wants and sees as important.*

Individual Leads the Meeting to the Fullest Extent Possible

Pre-planning is the best opportunity to assist the person in leading the meeting to the fullest extent possible. Activities that can help support the person to lead their meeting include:

- Working with the person to identify their comfort level with leading the meeting
- Assessing the person's level of self-confidence
- Practicing the leading of the meeting through role playing
- Helping the person identify what roles each team member should play
- Supporting the person to complete person-centered tools so they feel prepared and empowered to articulate their wants, needs, etc.
- Identifying parts of the meeting for the person and others to lead

Pre-Planning Tools

The Charting the Life Course (CtLC) tools and other planning tools can be used during the pre-planning process to help you gather information about the person from the person themselves or others from the PCST, prior to the PCP meeting. Although you can use any person-centered tool during pre-planning, DSPD recommends utilizing the LifeCourse Trajectory for Planning, Life Domain Vision Tool, Integrated Supports Star and the Relationship Map, in particular.

All Charting the LifeCourse tools are available to download for free at:
https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/

One recommendation is to fill out the Trajectory for Planning or the Life Domain Vision Tool prior to the PCP meeting so that the person's vision for a good life is identified and the support team is on the same page as the person. Then, complete the Integrated Supports Star tool at the PCP meeting so that the focus is on HOW the person will reach their vision.

Additionally, the Integrated Supports Star can be used to identify areas of discussion for the PCP meeting and help save time. The Integrated Supports Star helps brainstorm the supports people

already have or might need in order to work in partnership to make their vision for a good life possible.

The Relationship Map can also be useful to review with the person when determining who should be a part of their PCST as it assists the person with identifying people in their "circle." When filling out the Relationship Map, you may find it beneficial to highlight those people who the person wants to have at their PCP meeting. The Relationship Map is available to download for free at: https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Documents/Quad.RelationshipMap.pdf

You may also want to send an email or a letter to the person and/or their PCST with a few "questions to think about" prior to the PCP meeting. This can help support the pre-planning process and allow you to provide anticipatory guidance, as part of your role as a Support Coordinator, to facilitate expanded conversations (beyond services to life experiences) and support exploring possibilities. You may find the Quick Guides in the Life Experience Series useful during this step as each four-page guide contains a few questions from each of the life domains for that specific life stage: https://www.lifecoursetools.com/lifecourse-library/exploring-the-life-stages/

The Person-Centered Planning (PCP) Meeting

As a Support Coordinator, you help facilitate a person's Person-Centered Planning (PCP) meeting and support the person in leading the meeting to the extent they desire. The main focus of the PCP meeting is to discuss a person's hopes and dreams, and structuring services and supports to assist them in achieving their goals. The PCP meeting leads to the development of a Person-Centered Support Plan (PCSP) that will assist the person in achieving the life they desire.

The PCP meeting is person driven, meaning that it focuses on what is important to the person and accommodates the person's preferred communication and interaction style. A major function and outcome of the PCP meeting is identifying and planning the steps to help the person experience their "good life". Some questions you may consider asking during the planning meeting to help keep the focus on the person include:

- What would a "good life" look like to you? What do you want to make sure happens in your life?
- What is important to you?
- What are you good at?
- What do you like to do?
- Is there anything that you would like to do more of?
- If yes, how can others help you do more of what you want?
- What are your hopes and dreams?
- Is there anything preventing you from achieving your dreams?
- If yes, how can others help you achieve your dreams? What else needs to happen in order for you to achieve your dreams?
- What is going well? What is helping you achieve your dreams or taking you towards the things you want?
- What have you accomplished that you are the proudest of?
- What do you not want for your life? What do you want to avoid? Have you had any experiences you want to be sure do not happen again?

- For the PCST, what do others like and admire about the person?
- For the PCST, how has the person made a difference in your life? What have you learned from them?

Guided Conversations

Guided conversations are discussions with a specific topic and a prepared set of potential questions to help a person reach an informed decision. One of the hallmarks of guided conversations is the use of open-ended questions rather than closed-ended questions i.e., yes/no questions. Applying the concepts to Person-Centered Planning, foundational topics include: interests, relationships, community and overall happiness.[30]

Guided conversations help a person understand an idea, develop an opinion, and make an eventual decision.[31] As a person gains experience, the questions will be the same, but the responses change with time. The guided conversation should be person driven. All participants must offer full support of the desires of the person. Be careful not to let personal or PCST interests confuse the ideas the person is trying to communicate. Support Coordinators should pause planning as needed to protect against a process led by a professional and not the person, and preserve all steps of *Informed Decision Making* prior to writing the PCSP.

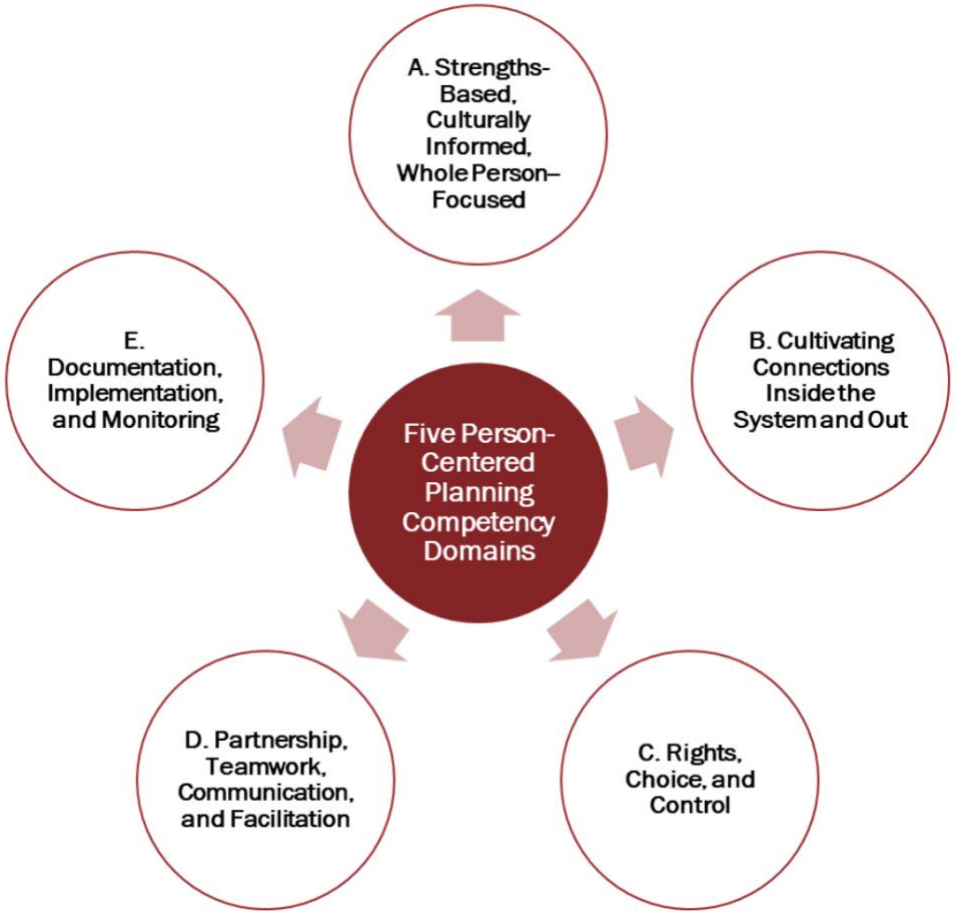
[30] Murphy, M., Sweet, M., (2009). The CORE of a Good Life: Guided Conversations with Parents on Raising Young Children with Disabilities. Retrieved from: http://www.disabilityrightswi.org/wp-content/uploads/2018/06/The-CORE-of-a-Good-Life.pdf

[31] State Employment Leadership Network, (2019). GUIDANCE FOR CONVERSATIONS: State Employment Leadership Network: Identifying and designing pathways towards rewarding employment. Retrieved from: http://static.smallworldlabs.com/umass/content/SELN-guidance-jan-2019.pdf

Five Competency Domains for People Who Facilitate Person-Centered Planning

While there are no universally agreed upon standards or competencies for professionals who facilitate Person-Centered Planning; such standards are needed to ensure that the planning process is consistent with the values of person-centered thinking, planning, and practice. The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) has identified five skill areas, or domains, that facilitators should possess to support a fully person-centered planning process.[32]

More detail regarding each of the domains can be found at the following link:
https://ncapps.acl.gov/docs/NCAPPS_StaffCompetencyDomains_201028_final.pdf



[32] Tondora, J., Croft, B., Kardell, Y., Camacho-Gonsalves, T., and Kwak, M. (2020). Five Competency Domains for Staff Who Facilitate Person-Centered Planning. Cambridge, MA: National Center on Advancing Person-Centered Practices and Systems.

Goal Development

A goal is a broad, meaningful and motivating statement which reflects something that the person wants to achieve. Goals are what the person wants the end result to be - not the supports to help them get there (not the means to an end but the "end"). Goals should be personal; written from the person's perspective and in their own words; and representative of what the person wants. Goals that are personal are designed based on what is important to the person, what they are interested in, what their values are, and what brings them happiness. Goals are not personal if they are focused on what the person needs (habilitation, health, and safety); what is good for the person; or what others think the person should want. There is no set number of goals for anyone; some people will only focus on one personal goal; others will have many. Remember that some people are big dreamers/long-term planners while others are more concrete short-term planners.

Some people are able to articulate their goals and desired results clearly, while others may find the concept of "goals" challenging; or can only hint at what is important to them. You can help people with goal development by identifying aspects of the person's life that they can draw from to move toward a specific goal and capitalize on their strengths. Goals can often unfold through reflective listening that highlights key things that seem important to the person.

Some questions that you can ask to help develop clear personal goals include:

- What are the most important areas of life you would like to see change?
- What do you want life to be like in the future?
- How do you want to spend your time (during the day, at night, weekends)?
- What do others who know you feel is a priority?
- What would success, progress, or a positive outcome look like this year?[33]

[33] Florida Agency for Persons with Disabilities (2018). Person-Centered Support Plan Instruction Manual. Retrieved from https://www.apd.myflorida.com/waiver/docs/DRAFT Person Centered Support Plan Manual 22818.pdf

Avoid goals that:

- The person has no interest in
- Just require attendance or participation
- Emphasize the absence of something
- Focus on the "improvement" of deficits associated with the person's disability

Reminder: services are not goals!

Once personal goals have been identified, consider the person's strengths and barriers, identify short-term objectives, and assist the person in deciding what services or supports - both paid and natural - will help them achieve their goal. Throughout this process, it is important to ensure that the whole support team understands and shares the same definition of success as defined by the person.

Planning Tool Tip

The Charting the LifeCourse tools can help in identifying some of the person's goals. For example, the person's vision of a good life is the ultimate outcome, but the goals are the things we want to work on right now in order to achieve that vision in the long term.

- Goals can easily be found in the "Moving Forward" box in the center of the Trajectory for Planning.
- You can use the Life Domain Vision tool to identify key priority areas to work on and develop goals in that way.
- You can use the Integrated Supports Star to identify the areas that may be "lacking"; and a potential goal could be further developing that type of resource (i.e.: greater use of technology, skill development, more relationships, etc.)

The dead man's test asks you to consider the question: Can a dead man do it? Think of a few goals and apply the dead man's test to it. If the answer is no, you pass the test. If the answer is yes, you do not pass the test and should brainstorm some ways of reframing the goal. If a dead man can do it, it's not an effective goal!

For example, if the goal is "Sam will not swear at others" this would not pass the dead man's test because a dead man could refrain from swearing. A better goal might be, "Sam will speak to others without swearing because he wants to improve relationships with his friends" because a dead man does not have the ability to speak or improve relationships.

Another example of a goal that a dead man can do would be, "Sarah will not eat junk food." However, if the goal was rewritten to "Sarah will start eating more healthy foods so that she can have more energy to do the activities she enjoys," a dead man would not be able to achieve the goal because he cannot start eating healthy foods or enjoy activities.

The Dead Man's Test highlights the importance of goals being dynamic and articulating why the person wants to work on the goal.

- Examples of things a dead man *could* do: be quiet, lay down, stay in one place

- Examples of things a dead man could *not* do: walk, talk, write, play, read, eat

Goal Writing

Goals are broad and general statements that provide long-term direction, and relate back to the vision of a good life and needs assessments. You will not need to address every personal goal identified during the Person-Centered Planning (PCP) process in the Person-Centered Support Plan (PCSP). Instead, prioritize what is most important to the person and what will make the biggest difference in their life; consider hopes, dreams, passions, and ambitions, as well as likes and preferences.

Some questions to consider when prioritizing goals include:

- What does the person want to focus on?
- What is most important to the person?
- What goal will make the biggest difference in the person's life?
- What is doable in the next year?
- What is better to categorize as a future goal?

The most important consideration when writing a goal is whether or not the person knows, understands, and is committed to their goals; and can explain how they link to their vision of a good life. Goals should not become so technical that they have little meaning to and for the person. Additionally, another crucial consideration when writing a goal is what successful achievement of the goal looks like to the person. How will the person know the goal has been completed? What are some of the indicators for achievement?

When writing goals, use person-centered language including the person's name, or "I" statements. You should avoid using "will" or "should"; and use "would like" or "wants" instead.

Statements to use:

- "John wants to…"
- "I would like to…"

Statements to avoid:

- "She will…"
- "They should…

Strengths and Barriers

When writing a goal, you will also need to consider the person's strengths that will assist them in achieving their goal, along with any barriers that have the potential to hinder their progress.

Strengths detail the strong points a person has relative to the specific goal and identify aspects of the person's life that they can draw from in order to move towards a specific goal, such as their family, natural support network, and community at large. Strengths capture the person's unique identity, resources, interests, competencies, accomplishments, and best qualities. Strengths also include environmental factors that will increase the person's likelihood of success, including strategies that have already been utilized to aid in the achievement of the specified goal. Strengths should be capitalized on and used to inform how the person may actively pursue their goals. For example, if the person would like to be employed and they enjoy reading, you may want to discuss potentially pursuing some volunteer opportunities at the library to see if that would be a potential career avenue they would like to explore.

Sometimes a person may not know how to describe their strengths so you may want to ask them questions such as, "What do you enjoy doing?" or "What do other people like about you or tell you that you are good at?"

While PCP should focus on acknowledging and utilizing the person's strengths, it is also important to address any internal and external barriers that have the potential to interfere with the person obtaining their goals. Barriers detail the struggles a person is currently having relative to that specific goal. Barriers can include, but are not limited to: need for skills development, intrusive symptoms, difficulty in activities of daily living, disruptions in meaningful relationships and roles, and threats to basic health and safety - diagnosis alone is *NOT* a barrier.[34]

[34] Spokane County (n.d.). Introduction to the Documentation of Person-Centered Service Plans. Retrieved from https://www.spokanecounty.org/DocumentCenter/View/3024/Introduction-to-the-Documentation-of-Person-Centered-Service-Plans-PDF

Some questions you may want to ask the person include:

- What is preventing you from achieving your goal?
- What is stopping you from doing it tomorrow?
- What prevents you from doing it on your own?

Remember: barriers should not be the focus of PCP, but should be used to inform the person's services and supports - both paid and natural - to assist the person in overcoming roadblocks and achieving their goals.

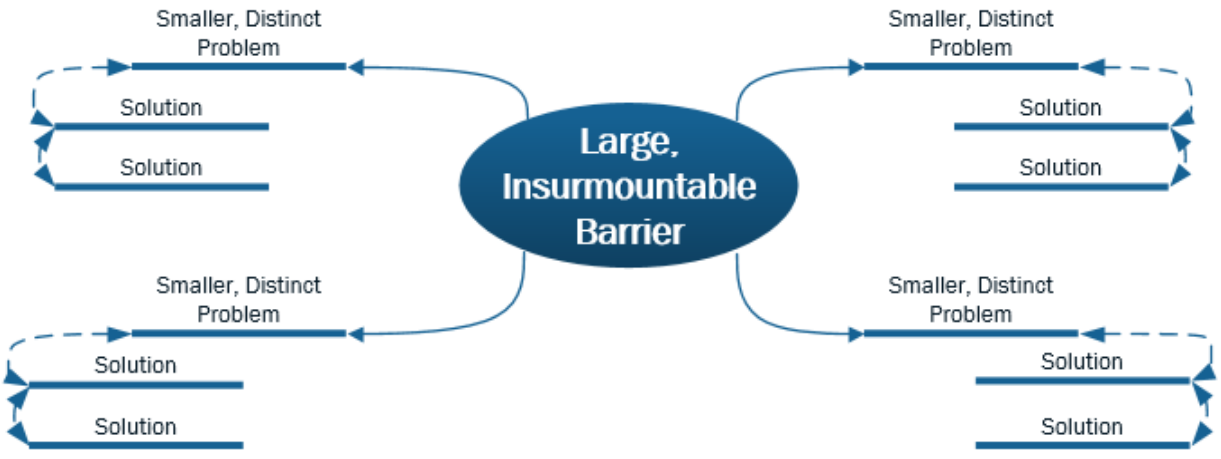
Planning Tool Tip

Strengths and barriers can be found in the two "Past Life Experiences" boxes in the Charting the LifeCourse Trajectory for Planning.

Think about a time when you, or someone you supported, overcame barriers to achieve a goal. What was the process? What steps did you take? How did you get past the barrier? What worked, and what did not work?

When working through roadblocks with people that you currently support, you may want to complete a spider diagram. Starting with input from the person and the support team, identify the barriers to the goal that seem large and insurmountable. Then, using a spider diagram, continue to break the barrier down until it reaches a collection of singular, distinct problems. Once you have reached this step, consider potential solutions to each specific problem; imagining that apart from this particular issue, the person faces no other barriers. After you have finished creating potential solutions for each problem, now consider the solutions again in the context of the other barriers and what is realistic and achievable right now. You may want to circle the solutions that remain feasible in the present moment.

You can create your own spider diagram or download some templates at Creately.



The Action Plan

The action plan is created by tying together the broad goal statements, the person's strengths and barriers, and the desired services and supports.

Example action plan:

Goal: John wants a job in the community that pays at least minimum wage. John will learn how to use public transportation independently by the end of May (six months).

Methodology/Support Strategy: how to accomplish the goal and how all integrated supports and services work together to leverage one another.

- Staff will help John learn how to read a bus map (including the route and times), interact with UTA staff for questions, and purchase tickets. Staff will take John on the local bus and train at least twice per week, for an hour, at different times of the day to help him become comfortable.

Duration: how long the goal/objective(s) will last

- After John has successfully navigated staff to a destination at least seven times, staff will drive to a predetermined destination to meet John (test if he can navigate on his own). John will have a cell phone to reach staff if needed.
    - Aim to accomplish this within six months of start date
    - December 1, 20XX - May 1, 20XX

Barriers/Modifications:

- John has an issue with getting distracted and has gotten lost on his own. Needs to build confidence with navigating public transportation before he does it by himself.
- John has a strong desire to work in the community to be more independent (financially, socially, etc.), but he cannot drive himself and his natural supports are unable to drive him to work daily. He lives close to a bus line and can use public transportation to help him get to work. He has not worked on this skill in the past.

At the End of the Person-Centered Planning (PCP) Meeting

Towards the end of the PCP meeting, take the time to summarize what was accomplished, what needs to happen next, and who is doing what. You should have decided and agreed upon goals and the action plan with the person and the PCST. Members of the PCST should walk away from the planning meeting with meaningful, clear and tangible roles in regards to the person's life.

You may find it useful to ask the person or members of the PCST for feedback on how the meeting went; and any suggestions for improvement.

Some questions you may consider asking the person after the PCP meeting include:

- Did you talk about things that were important to you?
- Do you feel that others listened to what you said?
- Do you feel that others respected your ideas and wishes?

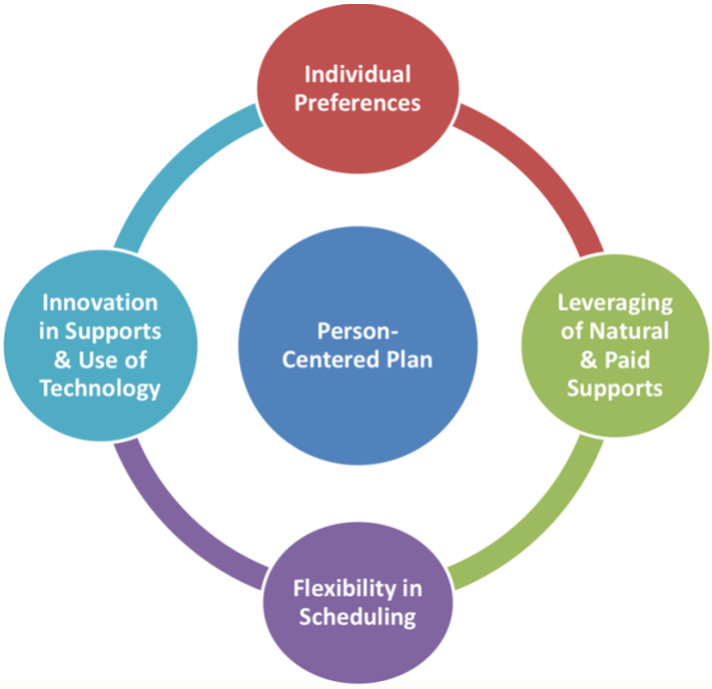
Some questions you may consider asking the PCST after the PCP meeting include:

- Does the plan seem workable?
- Did everyone feel listened to and understood?
- Did we identify all of the person's hopes and dreams to the best of your knowledge?

The Person-Centered Support Plan (PCSP)

The Person-Centered Planning (PCP) process results in a detailed, personalized Person-Centered Support Plan (PCSP) created by the person with support from their Person-Centered Support Team (PCST). The PCSP is where you document all of the information and decisions made during the PCP meeting.

The PCSP assists the person in achieving personally defined outcomes in the most integrated community setting. The PCSP is outcome-based, meaning that it focuses on increasing the experiences and opportunities that the person identifies as being meaningful to them. The PCSP also ensures the delivery of services in a manner that reflects personal preferences and choices; and contributes to the assurance of the health and welfare of the person.[35]



[36]

Everyone who receives Home and Community Based Services (HCBS) is required to have a PCSP. The PCSP must be reviewed, and revised upon reassessment of functional need at least every 12 months, when the person's circumstances or needs change significantly, or at the request of the person.

[35] Centers for Medicare and Medicaid (2016). System-Wide Person-Centered Planning [PowerPoint Slides]. Retrieved from https://www.medicaid.gov/sites/default/files/2019-12/system-wide-person-centered-planning.pdf

[36] Lollar, R., Lowe, S. (2016). When Practice and Policy Meet: Applying the CMS HCBS Settings Rule to the Goal of Promoting Community Integration in LTSS [PowerPoint Slides]. Retrieved from https://theconsumervoice.org/uploads/files/issues/Plenary_Session_11-5-2016_-_Serena_Lowe_and_Ralph_Lollar_Slides.pdf

Requirements for the Person-Centered Support Plan (PCSP)

The PCSP must reflect the services and supports that are important for the person to meet the needs identified through an assessment of functional need, as well as what is important to the person with regard to preferences for the delivery of such services and supports. Per CMS-2249-F/CMS-2296-F, the written PCSP must:

- ✓ Reflect that the setting in which the person resides is chosen by the person.
- ✓ Reflect the person's strengths and preferences.
- ✓ Reflect clinical and support needs as identified through an assessment of functional need.
- ✓ Include individually identified goals and desired outcomes.
- ✓ Reflect the services and supports (paid and unpaid) that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the person in lieu of HCBS and supports.
- ✓ Reflect risk factors and measures in place to minimize them, including personalized back-up plans and strategies when needed.
    - *Individualized back-up plan* means a written plan that is sufficiently individualized to address each person's critical contingencies or incidents that would pose a risk of harm to the person's health or welfare.
- ✓ Be understandable to the person receiving services and supports, and the people important in supporting them. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to people with disabilities and people who are limited English proficient.
- ✓ Identify the person and/or entity responsible for monitoring the plan.
- ✓ Be finalized and agreed to, with the informed consent of the person in writing, and signed by all people and providers responsible for its implementation.
- ✓ Be distributed to the person and other people involved in the plan.
- ✓ Include those services, the purpose or control of which the person elects to self-direct.
- ✓ Prevent the provision of unnecessary or inappropriate services and supports.

Rights Restrictions or Modifications

Providers and Support Coordinators must optimize a person's ability to make choices while minimizing the risk of a person harming themselves or others. There are times when a person and their PCST may decide it is necessary to restrict or modify a person's rights after all of the options for less restrictive interventions have been unsuccessful. A rights restriction is a limitation to the rights of a person due to a specific assessed need in order to support the health, safety, and well-being of the person or the community.

Rights restrictions or modifications cannot be implemented as "house rules" in any setting, regardless of the population, and must not be used for the convenience of staff. Restricting independence or access to resources is appropriate only to reduce specific risks. Controls on personal freedoms and access to community cannot be imposed on a class or group of people. For those restrictions that affect other people in the setting, there must be a way for them to circumvent the restrictions.

The process for implementing a rights restriction is person-centered. The restriction must be justified and documented in the PCSP. Per CMS-2249-F/CMS-2296-F, the following are requirements that must be included in the documentation in the PCSP related to the rights restriction:

- ✓ A specific and individualized assessed need. Documentation of a diagnosis is not sufficient justification. The assessed need for the modification must be clearly demonstrated and include critical events or situations that have transpired that support the need for the modification.
- ✓ The positive interventions and supports used prior to any modifications to the person-centered support plan.
- ✓ Less intrusive methods of meeting the need that have been tried but did not work.
- ✓ A clear description of the condition that is directly proportionate to the specific assessed need.

- ✓ A regular collection and review of data to measure the ongoing effectiveness of the modification.
- ✓ Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- ✓ Informed consent of the person.
- ✓ An assurance that interventions and supports will cause no harm to the person.

If the person chooses to direct some or all Home and Community Based Services (HCBS) through the Self-Administered Services (SAS) model, the PCSP must also describe the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods.

Prescribing Units and Services

The Person-Centered Support Plan (PCSP) is a living document. People's needs will inevitably change over time to satisfy the ongoing evolution of the person's needs. DSPD uses other processes, such as Request for Services (RFS) to help manage and monitor the content of the PCSP Budget.

Goals, Support Strategies, and Services

Requesting new, or adjusting an existing service results from observations or documentation that suggest a needs-based change is appropriate. The units prescribed for a service must match a planned time frame and require a written justification. Often unit amounts are documented through a schedule of the average amount of support needed per week. Justification for a service can be located in log notes, monthly summaries and daily data. This guidance is general as circumstances for each person are unique, emergencies and month-to-month variations are expected during a plan year. Needs-based changes should be requested as the PCST observes consistent over or underutilization of current services.

Determining the appropriate support level for a new service can be difficult. Often with new services, the person is adjusting to significant changes in routine. New staff, settings, activities and responsibilities (all changing simultaneously) can cause support levels to fluctuate during the first months of the new service. Support Coordinators should use professional judgement to determine the appropriate amount of services to request for a new service.

Planning Tool Tip

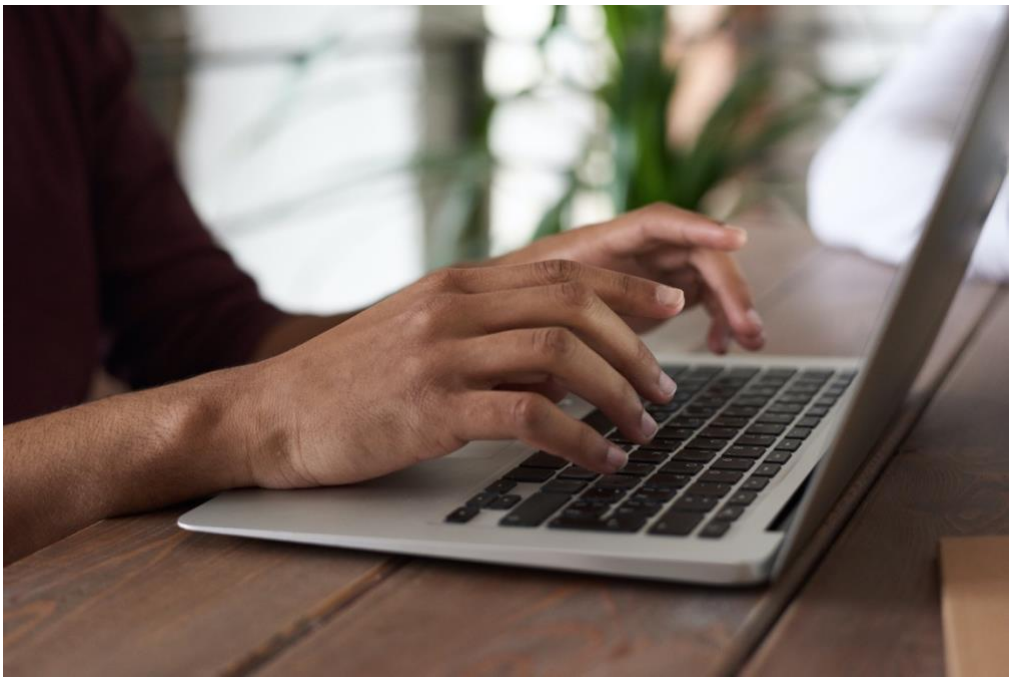
The Charting the LifeCourse Integrated Long Term Service and Support Needs Template can help with determining unit needs and planning allocations that make sense in the context of a person's life (and not the other way around).

When you are prescribing services consider:

- Information gained from pre-planning activities
- Goals, and whether the proposed services align with the goals;
- Will supports lead to positive outcomes, self-determination and independence?
- Do all of the services complement each other? Are there any overlapping services or conflicting goals?

Documentation and Justification

Justification for any prescribed service is critical. All Home and Community Based Services (HCBS) are determined based on need. Daily documentation provides evidence to support changes to services in the PCSP. In both initial budgets and requested changes through RFS (Request for Services) and emergency payments process, documentation is required. Support Coordinators should not need a lengthy search to find evidence to support service changes. When accurate documentation is collected daily, the justification needed to approve any budget request should be readily available. The only step left is to compile and submit all applicable information.



The Person-Centered Support Plan (PCSP) Budget

People's goals and preferences change over time. Therefore, Person-Centered Planning is an evolving process, one that encourages change and growth. A change in plans by the [person] is natural, healthy, expected, and encouraged.[37]

Adjustments to services or levels of support will rarely all occur at the end of a plan year. Funding Requests are available to meet these shifting needs and are submitted in four forms: an initial budget, an RFS (Request for Services), emergency RAS (Request for Additional Services) payments, and emergency requests. Each of the funding request categories are described later in this section.

The approved initial budget can be found in Pro-Forma. When plan changes are necessary, an RFS (Request for Services) should be submitted. A completed RFS should include: a description of the change, narrative justification for the change, and documentation needed to support the change. Once the request is submitted, all sections of the request are reviewed for relevance and accuracy. The decision will result in one of the following options: Approval, Modified Approval, Deferral or Denial. Emergency payments and requests ask for similar information, but follow a more expeditious process based on immediacy of need, existing risk for the person and health and safety.

Utilization of Services

As a Support Coordinator, you are responsible to help ensure each Person-Centered Support Plan (PCSP) is implemented ethically. PCSP budgets should always reflect the level of care the person needs for the length of the plan year. While short-term budget fluctuations over days, weeks or a given month are to be expected, underuse and overuse of services can be avoided through

[37] Condon, C., Fichera, K., Dreilinge, D., (2003). More Than Just a Job: Person-Centered Career Planning:Institute Brief 16. Retrieved from: https://www.communityinclusion.org/article.php?article_id=16

careful and consistent monitoring. A proactive approach is recommended when underuse and overuse of services is observed.

The proactive approach includes:

- an understanding of why each service in the PCSP is currently justified and how the service is delivered;
- assertive, time-sensitive response to needs-based changes.
    - These actions require careful reasoning and reliance on the professional judgement to determine the most appropriate response to the change. Some examples of appropriate case management responses are: draft a new RFS request, make a budget neutral change, coordinate additional community resources or support the person to find a different provider, direct staff or service setting.
- consistent awareness of shifts in service usage; and
- prevention of overuse through frequent communication with families and providers.

The proactive approach ensures support teams are anticipating the impact of current changes for an annual budget. Post-planning and monitoring responsibilities, if followed closely, will result in an accurate utilization of the PCSP budget.

Needs-Based (Budget Neutral) Changes

A valid needs-based (budget neutral) change can be implemented directly in the PCSP budget without submitting an RFS request. Validity of the change considers whether underused units or funds would be more appropriately and correctly assigned to a different service. This function *does not* apply to restricted service codes, budget neutral changes are *only* designed for services approved and prescribed in an active plan. When applicable, budget neutral changes create flexibility, discretion and accountability for support coordinators to make adjustments to services in the PCSP budget.

A needs-based (budget neutral) change is appropriate when the person requires a temporary or permanent reduction to one existing service and an equivalent increase is needed in another service. Pay close attention to patterns in billing and monthly service usage. Moving one-time funds, approved for one service, to fund an on-going need in a different service represents an inappropriate use of this process.

Preparing a Funding Request

A funding request should include narrative descriptions of the events prompting you to submit the request for a support change. If the only change needed is a decrease or an elimination, submit an email to your support service coordinator. If you are asking to increase the overall budget, requesting a service in a new category, or involving a restricted code, submit an RFS. Context is important when writing justifications and descriptions. Additional background information is beneficial and makes a decision much easier for a reviewer. Conversely, too much information, especially when unrelated to the request, can complicate the process and lengthen the time for approval.

The documentation you choose to support the request is evidence for any written description of the change. Only submit documents that support the request. The number of attached documents, in the form of incident reports, monthly summaries and log notes should be determined on a case-by-case basis. Attachments should provide an accurate picture of the current level of support. If a negative behavior, medical need, or other issue requires multiple reports as justification, including only most relevant reports is advised. Support Coordinators should document the history of the need to provide evidence for the request. As a recommendation for most funding requests, only include attachments between six months and one year from the submission date of the request as justification.

Reviewing the Request

Once the funding request is submitted, the proposed changes are thoroughly examined by a reviewer and in some cases a review committee. Based on all the information included in the request, one of four decisions are delivered:

- *Approval* - recommend the requested services be adjusted in the service plan as indicated in the request.
- *Modified Approval* - recommend an alternative solution to meet the support needs of the person. The request is sent back to the Support Coordinator to accept or reject. If a modified approval is rejected, a counter-offer can be submitted for further review. If the modified approval is accepted, the service plan is adjusted.
- *Deferral* - request is sent back to the Support Coordinator to clarify the information submitted or request additional information. The request can be rescinded, or revised and re-submitted.
- *Denied* - request does not meet requirements for RFS criteria.

Funding requests are not a guarantee of ongoing funding. The reviewers consider available funding, documentation, and other services appropriate for the person before a decision is reached. If all elements of the funding request are complete and accurate, the possibility of a "deferred" or "denied" decision is less likely. If your request results in one of those two options you can follow the direction assigned by the committee or appeal the decision to the waiver manager.

Emergency RFS versus Emergency Payments

Emergency RFS include some similar steps and requirements as an RFS, but since support needs are urgent and time sensitive a decision is reached more quickly. A Support Coordinator could expect an Emergency Request to be approved or denied within 72 hours of submission. Only one review, by the RFS Program Administrator, is required for approval. Include as much detail as possible in the Emergency Request. Additional context increases the likelihood of a quick

approval. The request should describe the emergency, severity of emergency, and any risks involved in waiting to respond. Emergency requests are decided on a case-by-case basis.

Emergency Payments procedures are activated when a provider is more than 90 days past a billing deadline and the Support Coordinator cannot submit an RFS as reimbursement for service delivered (in good faith) during the missed time period. Emergency payment requests should include a justification describing why the payment is overdue and include any documentation needed to support the payment.

Implementation and Monitoring

Person-Centered Planning (PCP) does not end after the Person-Centered Support Plan has been finalized and agreed to by the person. As a Support Coordinator it is your role to help ensure that the Person-Centered Support Plan (PCSP) continues to meet the needs and wants of the person.

As part of implementation and monitoring, you will conduct on-site, face-to-face visits with the person in order to monitor, review, and evaluate the services afforded to the person pursuant to their PCSP in order to ensure that services are delivered in the quantity and quality intended and that the services resulted in the intended outcomes. This will include:

- Interviews with the person in various service settings
- Direct observation of supports provided by Service Providers, Self-Administered Services (SAS) employees, or other natural supports
- Assessing the knowledge of Service Provider staff or SAS employees in the use and application of behavioral supports, medical conditions pertinent to the person, and support strategies for the person

The purpose of the visits is to ensure the health, safety, welfare, quality of life, and overall satisfaction of each person you serve. Specific information related to timelines and visit documentation can be found in your current Support Coordinator contract: https://hs.utah.gov/dhspurchasing

When conducting interviews and observations, it is important to focus your attention on how the PCSP is being implemented and what is, or is not, working. Some questions you may want to ask the person include:

- Have people done what they promised to help you?
- Have you been able to do the things you would like to do?
- Is there anything you would like to change about your services or supports?

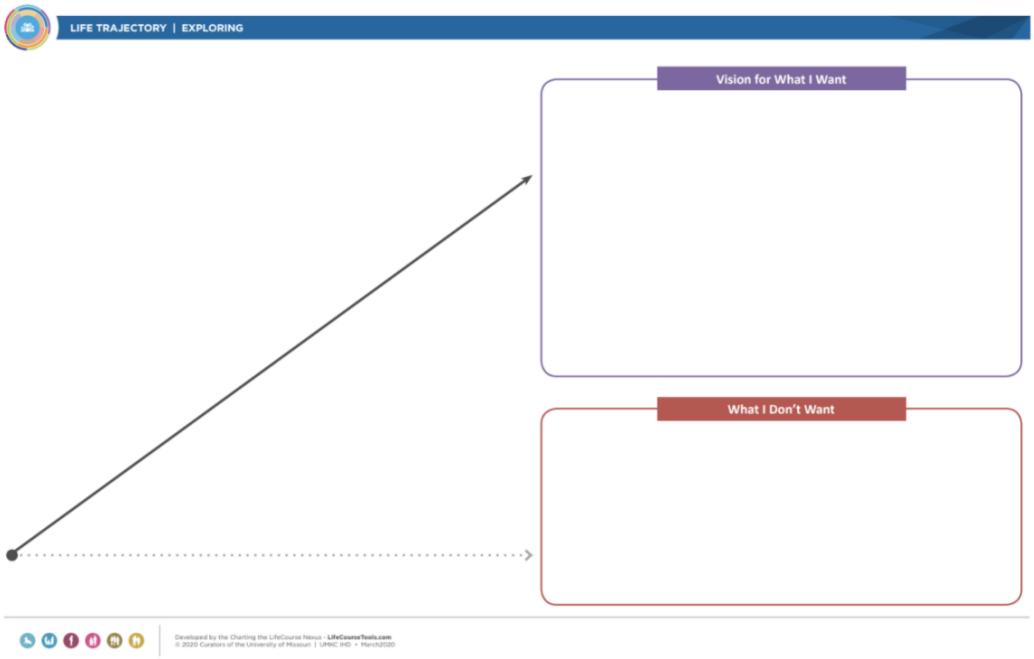
If it becomes clear through the discussion with the person that the PCSP is not being implemented as it should, or the person would like a change, consider what next steps you as the Support Coordinator may need to take.

You will also need to assess the degree to which services provided to the person are consistent with those prescribed in the PCSP, and the degree to which those services are assisting the person to achieve support strategy objectives and personal goals identified in the PCSP. Additionally, you should assess whether services in the PCSP are being provided in an appropriate location.

Planning Tool Tip

You may want to use the Charting the Life Course Trajectory for Exploring during your monitoring activities:
https://www.lifecoursetools.com/lifecourse-library/foundational-tools/person-centered/

You can have the "Vision for What I Want" and "What I Don't Want" sections filled out based on the PCP meeting and the final PCSP. When checking in with the person, use the left of the trajectory - above and below the line - to identify what is going well and what is not going well.



The person's services and supports should help the person achieve their vision of a good life, and should therefore, be modified as needed if they are not fulfilling that purpose. Over the course of the plan cycle, the PCSP may need to be amended due to changes to the person's needs or desires, or in response to certain life events or circumstances. In these situations, you should not wait to make changes until the next plan cycle, and instead coordinate with the person and their Person-Centered Support Team (PCST) to amend the PCSP.

Examples of when a PCSP should be updated include:

- Adding a service, support or goal
- Ending a service, support or goal
- Changing a service, support or goal
- Major life changes that affect services, supports, or goals

When there is potential that the changes to the PCSP would be significant and have a strong impact on the person, you should gather the person's PCST for a PCP meeting to discuss the possible amendments.

The Settings Rule

The Home and Community Based Services (HCBS) Settings Final Rule (or Settings Rule) is a federal rule that governs where and how services are provided to people receiving services under a Medicaid home and community-based waiver. The underlying principle of the Settings Rule is community inclusion for all Medicaid HCBS participants.

Per the Settings Rule, HCBS settings must:

- Be integrated in and support full access of people receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as people not receiving Medicaid HCBS.
- Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.
- Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimize, but not regiment, person initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitate individual choice regarding services and supports, and who provides them.

Provider-owned or controlled residential settings must also ensure each person has:

- A lease, residency agreement or other form of written agreement
- Privacy in their sleeping or living unit:

    - Units have entrance doors lockable by the person, with only appropriate staff having keys to doors.
    - Individuals sharing units have a choice of roommates in that setting.
    - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- The freedom and support to control their own schedules and activities, and have access to food at any time.
- The ability to have visitors of their choosing at any time.

If at any point during your post-planning or monitoring activities, you have any concerns about a setting not being in compliance with the Settings Rule, email HCBSSettings@utah.gov. If you have any feedback related to the Settings Rule that requires immediate attention due to health and safety concerns, please call 801-538-6613.

Resources

Division of Services for People with Disabilities (DSPD) Settings Rule webpage:
https://dspd.utah.gov/settings-rule/
Utah Department of Health (DOH) Settings Rule webpage:
https://medicaid.utah.gov/ltc/hcbstransition/
The Council on Quality and Leadership (CQL) Settings Rule video series:
https://www.youtube.com/playlist?list=PL_6PLdSIhcvNW7Tl77a-DdTGvSp_H1gBl

Thank You To…

The Utah National Center on Advancing Person-Centered Practices and Systems (NCAPPS) Team

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The DSPD Person-Centered Support Plan (PCSP) Rewrite Workgroup

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Feedback on this handbook can be submitted at the following Google Form link:

https://forms.gle/kYNV8rC3V5EnV9WRA